S. HRG. 103–730

VA PARTICIPATION IN STATE HEALTH CARE REFORM PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

FEBRUARY 9, 1994

Printed for the use of the Committee on Veterans' Affairs

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VA PARTICIPATION IN STATE HEALTH CARE REFORM PROGRAMS

WEDNESDAY, FEBRUARY 9, 1994

U.S. SENATE
COMMITTEE ON VETERANS' AFFAIRS
Washington, DC

The Committee met, pursuant to notice, at 2:08 p.m. in room SR–418, Russell Senate Office Building, Hon. John D. Rockefeller IV (Chairman of the Committee) presiding.

Present: Senators Rockefeller, Daschle, Murkowski, Simpson, and Jeffords.

Also present (staff): Jim Gottlieb, chief counsel/staff director; Diana M. Zuckerman, professional staff member; Kim Lipsky, legislative aide; and John Moseman, minority staff director/chief counsel.

OPENING STATEMENT OF CHAIRMAN ROCKEFELLER

Chairman ROCKEFELLER. Good afternoon, everyone. I welcome you to this hearing.

There are a lot of us in these two bodies of Congress who are struggling very hard against what appears to be a well-financed and certainly very hard-working effort to kill all chances for national health care reform. But while we do this, there are a number of States who have shown us that reform can happen. When the needs of constituents outweigh the needs of commercial interests or special interest groups, reform can be accomplished in the States. And it certainly ought to be able to be accomplished at the national level.

Universal coverage and employer mandates may be debatable issues in Washington, DC, but they are essential ingredients in health care reform in Washington State. Everybody who has testified before the Finance Committee has said basically the same thing: You don't get universal coverage unless everybody participates; you don't get everybody participating on a voluntary basis, so you have to have mandates. Almost without exception, all witnesses have said that. Health alliances appear for some reason to be frightening to some, but not to the people of Minnesota, or Florida, or the State of Washington, because they have already decided they are the best way to provide cost-effective medical coverage for their citizens.

I applaud the efforts of the various States that are moving full-steam ahead with plans for health care reform. I advise my own State not to wait for the Federal Government, but to go ahead and get your own health care reform going. These States and their various plans

give us a very good opportunity to learn from their successes and to learn from any problems that they might have along the way.

In addition to illustrating how various reforms work in the real world, State reform programs will show us how reforms affect existing Federal medical programs, including the VA medical system.

Unfortunately, current Federal law makes it impossible for VA facilities to participate fully in statewide health care reform efforts. It amazes me that, with the exception of one plan—the President's plan—none of the plans introduced in the Congress have anything to say about the Department of Veterans Affairs. I don't understand that. The largest health care system in the country is being totally ignored by all but one plan. A variety of restrictions enacted for good and noble reasons, I'm sure, will prevent VA facilities from competing against other providers in those States. We will hear examples of those restrictions at today's hearing.

As Chairman of the Senate Committee on Veterans' Affairs, I want to make sure that all our veterans get the best possible care in those States and across our country. I strongly believe that Congress must act quickly to enable VA facilities to participate in some of these State health care reform efforts, in order to strengthen the VA health care system in those States and to enable us to learn what kinds of changes are needed in the VA medical system as a whole. Of course, all States will be able to participate in State or national health care reform activities when Congress passes a national bill that revises the laws governing the VA health care system, which we will do. In spite of everything that has been going on, we will have comprehensive national health care reform by the end of this year. You can put that in the bank.

At today's hearing, we will hear from some of the VA officials and advocates who have a vision of how medical services for veterans can be improved through health care reforms, and how a pilot study in several States can make sure that happens.

We will focus on five of the States that are moving most quickly to implement health care reform: Florida, Minnesota, Tennessee, Vermont, and Washington State. We will learn what is needed to enable the VA medical centers in those States to participate in health care reform, and what Congress needs to do to help make that happen.

[The prepared statement of Chairman Rockefeller appears on page 42.]

Chairman ROCKEFELLER. Now, I am very pleased to welcome our first panel, which consists of directors and chiefs of staff from VA medical centers in States that are moving ahead with health care reforms. These witnesses are responsible for the day-to-day administration of hospitals and for negotiating with State officials. With us today are Dr. Robert Petzel from Minnesota; Mr. Joseph Manley from Washington State; Dr. Howard Green from Vermont; Mr. Malcom Randall from Florida; and Mr. Larry Deters from Tennessee. Gentlemen, please have a seat. Thank you all for taking time to be with us.

Unfortunately, we did not receive your written statements two days ago, as required by Committee rules. That was, however, not

your fault. All of you prepared your statements last week and this unfortunate situation, which has caused great inconvenience to us, was caused by the VA Central Office, not by you. I don't like that. I want to convey to Secretary Brown that we rely on the Department of Veterans Affairs to make these hearings as informative as they can be. If any of the testimony was altered, which I am certain in some cases it was, I don't like that; I don't like that one bit. That hints of VA manipulating the real and honest feelings of what it is you have to say or might want to say to us.

I would say to VA that we will not in our oversight position be pleased if they continue to do that. And if they continue to do that, we will make it a public issue and we will go to the mat on it. You all work hard all day long every day, and you know what you're talking about; you don't need to have somebody filter your testimony, which then, in turn, makes it difficult for us to get it. We will have to do a better job in the future, and I guarantee you that we will.

So for this hearing, because of the inconvenience caused by VA Central Office, each of you will have to be sworn as witnesses, which I find most awkward, most uncomfortable; but since I want to be sure that what we're hearing from you is what you need to tell us, and not what somebody says might please them better, I am going to swear you in. That is also a little message to the VA Central Office, and I hope they are listening. In place of any statements that you might have prepared, after I swear you in, I would like to ask just two questions. You will have a minute or two to tell us the status of health care reform in your State; then tell me briefly what you need from us in order to participate in health care reform in your State—what kinds of legislative changes or autonomy your State VA facilities need to participate and to succeed.

So, now we will do our oath. Please rise.

Do you swear that your testimony will be the truth, the whole truth, and nothing but the truth?

[Chorus of "I do's".]

Chairman ROCKEFELLER. Let the record show that the witnesses all answered in the affirmative.

Now I will call upon Senator Murkowski, our distinguished ranking member from Alaska, who came in just after our distinguished unranking member from Vermont.

OPENING STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. Thank you, Mr. Chairman. And I came in just before our friend from Wyoming. In any event, I want to commend you. I think this is a significant hearing because Federal reforms, while underway, are not finalized by any means. So we have a lot of work to do.

States have proven the adage, like other issues, health care is certainly local, and many States are reforming their health care systems now. I understand that National Governors Association testimony last week confirmed the need for coordination in the Federal-State efforts. The Federal Government must give the States the flexibility to move forward, and it is this last issue of flexibility that we're concerned with today. Without it, I believe we would lose

the benefits that entrepreneurs and innovative VA medical center staff would bring to the facilities and the system as a whole.

Last year, this Committee heard testimony from GAO regarding the potential for veterans to leave the VA health care system. When universal coverage offers the veteran and the veteran's family affordable alternatives, GAO said that up to 50 percent of the veterans currently using the system may give it up and chose another option. The PVA did a similar study that suggested up to 25 percent would leave the system. Regardless of whether you believe those figures or any others, the impact on VA would be substantial.

The highlights of the testimony here today indicate significant necessity for having answers relative to the role on the local level with regard to State reform and efforts thereof. The flexibility to make necessary changes at the facility level is key to VA's success in a reformed health care system. In blunt terms, VA must attempt to maintain its patient base in those States that are reforming their systems now.

Each State represented at the hearing has passed some kind of a comprehensive health care reform. I am hoping today we can learn what kind of barriers the VA facilities in each State have confronted when addressing VA's role in those reforms and how those barriers can be overcome. So we look forward to the testimony, Mr. Chairman.

Again, I think the issue of flexibility is one that we're all concerned with. What happens to the veteran that traditionally made him or herself available to the VA facility when now they are going to have the option of choosing a facility down the street or around the corner or in the next block? I certainly don't know the answers, but we will look forward to the testimony.

Thank you, Mr. Chairman.

Chairman ROCKEFELLER. Thank you very much.

I am going to call next on Senator Jeffords. It says right here that Senator Simpson will not be attending.

Senator MURKOWSKI. Where is he?

Chairman ROCKEFELLER. Yes. Oh. [Laughter.]

Senator SIMPSON. Well, I came over here to terrorize you. [Laughter.] No, I didn't. Nice to see you, Mr. Chairman.

Chairman ROCKEFELLER. Thank you.

OPENING STATEMENT OF SENATOR JEFFORDS

Senator JEFFORDS. Mr. Chairman, I will proceed then. It is a pleasure to be here today and to represent one of the five States that will be testifying. I am looking forward to hearing their testimony. I am especially pleased to welcome Dr. Howard Green from our great VA center in White River Junction, VT.

This is a very important hearing for the Senate Committee on Veterans' Affairs as we continue to further discuss health care reform. The VA must continue to play a prominent role in our Nation's health care system, and, therefore, must be able to work with new State health care reform initiatives.

As our Nation's largest health care provider, VA offers expertise in a wide range of health care areas and research. President Clinton has laid out his plans for VA participation in his health care reform

package. I support his reform initiative but I want to be sure that VA will be able to fairly compete with the private health care options. VA eligibility reform must coincide with health care reform if VA is to compete.

This Committee will propose legislation that will take advantage of progressive State initiatives. Several pilot programs will be set up to determine how VA can best furnish health care services in States with reformed health care systems and under any national health care reform plan that may be enacted. All the States' health reform efforts offer opportunities for VA to capitalize on its future role in national health care. Vermont's reform efforts are well underway and will allow VA to experiment hand-in-hand with reform.

This is a critical and exciting time for VA. For the first time, all veterans could be eligible to receive care at a veterans medical center regardless of their service connection. However, VA needs to be prepared to make the proper changes that will let it remain a contender in the health care arena when national health care reform is implemented. I believe the VA pilot programs in this regard are extremely important and offer a crucial insight into the future capabilities and services that VA will provide.

It is extremely important that we consider not only setting up pilot programs in States that have already implemented health care reform, but also in States, like Vermont, which are in the process of reform. The VA must be prepared to play a role during the process of implementation and transformation.

I look forward to hearing more about these States' health care plans and the initiatives VA is planning to take in order to work with the new State reform efforts.

Thank you, Mr. Chairman.

Chairman ROCKEFELLER. Thank you, Senator Jeffords.

Senator Simpson, do you wish to make a statement?

Senator SIMPSON. No, Mr. Chairman.

Chairman ROCKEFELLER. Really? Not a word of wisdom?

Senator SIMPSON. Mr. Chairman, my wisdom comes from sitting in that chair for a few years, as did my friends Al Cranston and Frank Murkowski. I just want to say that I do admire what you do with this hearing schedule and what you're trying to accomplish. This is a serious issue. I just wanted to drop by and say that this is what you will see in VA's participation in state health care reform programs. You indicated that you were somewhat concerned that the VA Central Office held up the individual VA center testimony for today's hearing. I have seen that before, also.

Chairman ROCKEFELLER. I had not and I don't like it.

Senator SIMPSON. It was never anything that I appreciated, and I admire your courage in addressing the matter, because it is wrong. But there is a great heavy hand in VA Central Office, no matter who is running the shop. They desperately try to still the voices of innovation. So I admire what you're doing, and I think it is very important.

When you give a lot of veterans an option to go down the street for their health care, as Frank said, they are going to go down the street. We better be ready for that, especially when we now see a budget

where they are going to build another hospital and another nursing home and, yet, the number of veterans will continue to decline. That is reality. But the symbolism, the bureaucracy of it, will continue because no one will ever vote against the word "veteran" around here. I have been through all of that. But at some point in time, we will find ourselves overbuilt, and with a health care system—whatever it is, a blend of Clinton, or Chafee, or Cooper, or Nickles, or Graham, or Durenberger plans—we'll get something and when we get it, VA may be stung in the process. It is going to be very interesting to hear what we need to do in a realistic way.

I do admire what you do or try to do with regard to this issue. But when you mention the word "veteran," just get out of the way before the Congress tramples you in the process. And that is wrong. I have been saying that for a lot of years, probably will continue to say it to my detriment. They are looking for me all over the State. [Laughter.] But they give me an award every now and then, and it is quite nice. [Laughter.] I thank you, Mr. Chairman.

Chairman ROCKEFELLER. This is a serious hearing, but, and Senator Simpson knows this—I will never forget, Senator Murkowski and Senator Jeffords and Mr. Moseman, my wife Sharon and I were driving back from our farm in West Virginia one night—because my wife works for public broadcasting, of course, there is no choice as to what we listen to—and Senator Simpson was on, and he was really on. He was on to the extent that my wife and I pulled off the road onto the shoulder, which you do, you know, when you have a blinding snowstorm of some sort, and we did that because we just didn't want to miss a single syllable, I think decibel might have been—[Laughter.]

Senator MURKOWSKI. Is that because you were laughing? [Laughter.]

Chairman ROCKEFELLER. No, no, no. I was writing like crazy.

I want to point out also that Malcom Randall who is here is a very key advisor to Senator Graham, so let the record show that.

Sir, we start with you. Do you remember the questions that I asked?

Dr. PETZEL. I think so, yes.

STATEMENT OF ROBERT A. PETZEL, M.D., CHIEF OF STAFF, MINNEAPOLIS, MN, VA MEDICAL CENTER

Dr. PETZEL. Mr. Chairman, members of the Committee, good afternoon. My name is Robert Petzel. I am the chief of staff at the Minneapolis VA Medical Center. On behalf of the veterans of Minnesota, I want to thank you for the opportunity to speak.

Minnesota passed health care reform legislation in 1992. These laws reformed the State medical care delivery system by mandating universal coverage, encouraging providers to collaborate by forming integrated service networks (ISN's), requiring ISN's to provide a uniform benefit package, encouraging employers to join with one another to form health purchasing cooperatives, and limiting the reimbursement of non-ISN providers through an "all payer" State system.

Some of the characteristics of this plan include facilitating enrollment of people with severe medical conditions by using

community rating, providing primary care within the lesser of 30 minutes or 30 miles of each constituent in the State, providing primary care within 10 miles of any city with a population greater than 2,500, providing inpatient care within 60 minutes of travel, and requiring ISN's to accept eligible enrollees who may reside anywhere in the State.

The program has begun. There are 90,000 people enrolled in the State of Minnesota so far. Beginning in July, the true ISN's will start to be formed and the universal coverage program will become available to all citizens of the State.

The Minneapolis VA Medical Center is responding to this by developing a contractual primary care network around the State so that we will be able to provide primary care within 30 minutes or 30 miles of any veteran living in the State, again, doing primary care by contract and providing the secondary and tertiary care at our medical center.

We are also involved in the joint development of a managed care institute with a large HMO-type health care provider in the State using the VA's Enhanced Use Program. We expect to develop an institute for primary care research and education with this HMO.

And finally, we're in the midst of tremendous internal changes in an attempt to cope with health care reform in Minnesota and to become a provider of choice for those veterans who we feel under MinnesotaCare will have a choice.

The things that we need in order to compete are (1) flexibility in terms of our management prerogatives, and (2) enhanced contracting authority.

Chairman ROCKEFELLER. Wait a minute. I don't understand that. With whom? Do you mean with Central Office?

Dr. PETZEL. We need to be able to use the resources that we have, our FTEE, our money, in a completely and totally flexible manner. We need to have all those things available for whatever we think we need to use them for. If we need to take the medical care appropriation and use it to spend $5 million contracting for primary care around the State of Minnesota, we have to have the flexibility to be able to do that.

Number two, we need enhanced contracting authority. We need to have that virtually delegated down to our medical centers so that we don't have to come back to Central Office repeatedly for any contract over $25,000.

The third thing we need are several years of nonrecurring resources. We expect to be able to do this eventually with our recurring base. But in the meantime, in order to get this established, we do need nonrecurring resources. And it would help us considerably if there were eligibility reform. In that manner, I mean the ability to provide the same level of in and outpatient services to all veterans who are seeking care from us who are in general eligible.

What will happen to the veterans in the State of Minnesota under MinnesotaCare is that they will, in the short term, have more options available to them, we think. However, if we are not allowed to compete, we believe that eventually our patient base will be eroded, and our ability to deliver services to those veterans who need it in our

State will thus eventually be eroded if we are not allowed the freedom to compete.

Thank you.

[The prepared statement of Dr. Petzel appears on page 46.]

Chairman ROCKEFELLER. Thank you, sir, very much.

We will just go right through. Mr. Manley.

STATEMENT OF JOSEPH M. MANLEY, ASSOCIATE DIRECTOR, SEATTLE, WA, VA MEDICAL CENTER

Mr. MANLEY. In 1993, Washington State enacted a reform plan that is very similar to what has been proposed by President Clinton for national health care reform. The Washington State law provides universal coverage, is a managed competition plan with premium and payment caps, creates a uniform benefit package, provides subsidies for low income enrollees, and provides skilled nursing facility, home health, and hospice services.

A five-member commission is now at work holding public hearings and developing the structure for the law to function within the State. They have a mandate to deliver to the legislature a complete product by December 31 of this year.

Beginning in February 1995, the health plans will be certified and they will begin enrolling citizens. Every State resident, including all veterans, will be required to obtain the uniform benefit package by July 1999. A unique feature of the Washington approach is that they are starting the implementation with the wealthiest, healthiest, best insured population in order to have the funding necessary to create all the administrative structures and delivery system within the State before they enroll other citizens. In time, the rest of us will join the initial enrollees in the established plans.

Speaking on behalf of the directors of all the VA medical centers in the State, we feel we need help in six areas. One is increased management flexibility. This includes the ability to go out and contract with family doctors throughout the State so the veteran can get care near his home. Also, the ability to do leasing, sharing, joint ventures with the public sector and the private sector when they make sense. We have a large military presence in Washington State with naval, Air Force, and Army hospitals. We hope to join into a consortium with them so that we deliver Government care in the most cost-effective manner. We would need flexibility to advertise and to hire consultants for expertise in actuarial services, in advertising, and in creating networks. In the absence of local decision authority, we need a very quick approval process through VA channels.

We also need adequate financing. We feel our clinical workload should be financed and should be based on enrollees so that the more people who enroll in our plan, the more resources we have to treat them. We would ask for the same resourcing kinds of constraints that our competition is going to operate under. We would, of course, need a separate appropriation for education, research, Department of Defense backup, and any special Government subsidies that are approved for veterans.

We would need to enroll family members. Studies show that females make 85 percent of the health purchasing decisions. They are

also critical in the health and welfare of the veterans since they are the caretaker through much of the year. It makes sense that veteran families have a single family doctor.

We would like to mirror the private sector in many ways so that VA is perceived as good as or better than what a veteran would get in the private sector. We think that managed competition needs a levelled playing field for all players, and we would accept the challenges along with the rewards of that system.

We feel we must focus more on the customer. That is much more than just delivering quality care in a timely manner; that is having the ability to deal with restrictions on market surveys like the Paperwork Reduction Act. The State of Washington will require us to collect patient satisfaction information and provide them with details of the surveys. They envision providing rankings of all the health plans because the citizens get to choose from among at least three offered plans annually.

And lastly, we must meet the State's requirements to be a certified health plan. That means offering the uniform benefit package to all enrollees at a minimum.

Chairman ROCKEFELLER. And you have some quality controls? Any quality oversight?

Mr. MANLEY. We have quality oversight now. The State will require additional ones and different ones that we will have to adjust to.

[The prepared statement of Mr. Manley appears on page 47.]

Senator MURKOWSKI. Mr. Chairman, just one or two questions. Mr. Manley, in reading over your statement, you say, "It provides subsidies for low income enrollees." That would be the State that would provide that funding?

Mr. MANLEY. Yes, Senator. In the Washington State approach, the State will be divided up into four geographic areas with a health insurance purchasing cooperative in charge of each area. That cooperative will collect premiums from employers, from citizens, from Medicare/Medicaid, and add State tax subsidies.

Senator MURKOWSKI. What percentage from the employers?

Mr. MANLEY. The employer will be required to pay a minimum of 50 percent of the lowest price plan. They may pay up to 100 percent, though.

Senator MURKOWSKI. And that's been adopted, so that's it?

Mr. MANLEY. Yes, Senator.

Senator MURKOWSKI. The President's plan is 80 percent and yours is 50 percent.

Mr. MANLEY. Yes, sir.

Chairman ROCKEFELLER. What we need to do is also get from each of you what it is that you need in order to participate in this pilot project—not just what you need to do to get health care to work, but what you need to get into a pilot project. Maybe both of you would just like to add something about that.

Mr. MANLEY. We would need some startup funds, venture capital, if you will, to create the primary care network near the veteran's home and also to create the corporate umbrella structure for our separate areas to operate under.

Chairman ROCKEFELLER. You mean you need to get that from us, or from your own State legislature?

Mr. MANLEY. We would need to get that from the Government somehow.

Chairman ROCKEFELLER. From this one?

Mr. MANLEY. Yes, sir, from the Federal Government.

Chairman ROCKEFELLER. Yes. Dr. Petzel, you said that you don't need money in your State?

Dr. PETZEL. We don't need recurring money. We would like to have nonrecurring money—wouldn't like to, we need to have nonrecurring money over a period of 3, perhaps 4 years in order to get this program started. But we feel we can generate from our recurring base the money to sustain this eventually. We already have the health care reform legislation from the State, so we don't need anything from the State; the State has accommodated very nicely to the needs of the Department of Veterans Affairs.

Chairman ROCKEFELLER. Senator Daschle has come in. Do you have any questions?

Senator DASCHLE. I have no questions.

Senator MURKOWSKI. I just have one other quick question. That 50 percent, is that deductible to the employer from the State as well as Federal Government?

Mr. MANLEY. I don't know the answer to that, Senator. I can provide that for the record though.

Senator MURKOWSKI. Yes. That's fairly important.

[The information to be provided appears on page 105.]

Chairman ROCKEFELLER. And you indicated that you had a mandate, everybody participating?

Mr. MANLEY. That's correct, Mr. Chairman.

Chairman ROCKEFELLER. Dr. Green.

STATEMENT OF HOWARD H. GREEN, M.D., CHIEF OF STAFF, WHITE RIVER JUNCTION, VT, VA MEDICAL CENTER

Dr. GREEN. Thank you, Mr. Chairman, and members of the Committee. I would like to give specific credit to Senator Jeffords for his strong support of our role in the Vermont health care plan as it evolves and his willingness to testify in front of the State legislature to that extent.

Chairman ROCKEFELLER. Senator Jeffords did this?

Dr. GREEN. Yes, he has agreed to do that.

Chairman ROCKEFELLER. Oh, that's great.

Senator JEFFORDS. Thank you.

Dr. GREEN. I must admit, sir, as I looked at Senator Jeffords' biography, I realized that he was 7 days older than I am, but I am catching up very quickly.

We are in a very interesting status in the State of Vermont because we're in the initial dialogue in the crafting of legislation. Act 160 of the legislature in 1992 required the State health care authority to present a plan to the State legislature that would deal with two separate plans—one a multipayer plan and the other a single payer plan. Regardless of the payer plan, there were some principles that were in the report that seem to be at least still alive in the legislative

debate, although the lobbying is ferocious. One is the principle of universal access; the second is a benefit plan; the third is purchasing alliances for health care; the fourth, although controversial, is 30-minute access to primary care to the constituents. Of course, 100 percent of the population would be covered, and global budgets would start beginning in 1995. Those principles seem to be the nub of the debate, if you will.

The medical center at White River has been actively involved in this process because our chief of medicine was appointed to the advisory board which has worked with the health care authority. So we have had a chance to educate the State legislators about VA and what it can do for the State. We have also educated them on the role of benefits VBA has in the welfare of patients in general. That cannot be ignored because the data is clear that health status is related to income. So it is a twist that they didn't understand.

We have an observation about the process in that most State legislators are ignorant of VA programs. They really have no idea about the role that VA plays in their States in terms of health care for veterans or the benefits package.

As I said, the dialogue is intense. Our presence is increasingly being recognized because we are getting calls from legislative committees asking our advice on things such as long-term care, which to us is a good sign. But we really don't know how this legislation is going to take shape. Because Vermont is a populist State, we think that they will maintain those principles that I have just voiced, and I think if not all of them initially, it will evolve to that point.

In anticipation of that in Vermont, we have begun a strategy to make ourselves salable, if you will. There is no way we can be salable unless we can put the care where the veterans are. In a rural State, that's a real problem because rural States are different than the urban States. There are natural domains of primary care that are noncompetitive. If you are seen as a competitor walking in, taking away business from the local providers, rather than as a friend providing revenue, you are put at a disadvantage. And as the late Tip O'Neill said, "All politics is local," all health care is local in that paradigm. So we have to be seen as a collaborator rather than a shark of a competitor. It is the dialogue that will allow us to do so.

I would say to you that there are pilots and then there are pilots. We do not have the local expertise on managed care, although we're learning quickly, to get in this debate at the level we ought to. What we need immediately at White River, because we are in the debate to be in a pilot program, is outside expertise. And if you want to bring it down to money, money is the issue, because we don't have the flexibility in our hospital budgets to buy these kinds of people. We also have to have knowledgeable people helping us with the legwork that it takes to work with the legislature. It is a very complex process, and you have to stay on top of it all the time.

In the short term and in the long term, we also are going to need certain authorities that are not yet delegated to medical centers. In the short term, I couldn't agree more with what Dr. Petzel and Joe Manley have said. We need short-term startup funds, nonrecurring funds to allow us to operate. We need flexibility in budget manage-

ment to move funds between accounts. We have to have the startup capital that I told you about. We need changes in the rules for contracting and sharing authority immediately, and I would like to give a twist in a rural State to that. As we go through the process of downsizing Government, yet at the same time trying to prepare ourselves for competition in this environment, rural States have a different problem than urban States, and let me be very specific.

I said it this morning to some colleagues. I said, "If I put out a contract for certain services in my area, I would be lucky to have a moose respond, because there just aren't that many contractors giving the services in a rural State as there are in an urban setting." So we need a window of time of relief to get our act together; and I think that's the best way I can put it. We can't be cutting on one end and gearing up for competing in the health care arena on the other end. That's the truth, sir, in a rural environment.

We also are going to have to take a different view of our personnel policies. We have got to be able to hire the people that we want rapidly. If we are truly going to be in competition, we need that kind of latitude. We are going to have to have a way to find different streams of revenue, whether it be from the State or a multipayer system, however it comes, and have that revenue go to us for giving the care. We are going to have to solve the problem of how does a VA hospital that is sitting on a State border serving two-thirds of its veterans from one State, one third of its veterans from another State, react to the various health care plans, and how are we going to integrate the current veterans eligibility rules into that. We are going to have to be able to market. But I would put a word of caution out. We have some real problems in the VA system with clinic times and this sort of thing, and the biggest mistake would be to market what we can't deliver. We obviously need a system so that our central organ can oversee the process. That means that we need advanced information systems to tell the real facts on the product lines that we are developing. We also have to have a way to find patient need. That seems strange, but frankly, unless you know what your customers need, you can never craft a plan to serve them. And the ways that we have to go about doing that now have very heavy restrictions on approvals of questionnaires and these sorts of things that take so much time. You are behind the power curve before you start.

I appreciate this chance to mention some of the things that we need. I will be pleased to answer questions later. Thank you.

[The prepared statement of Dr. Green appears on page 49.]

Chairman ROCKEFELLER. Thank you, sir.

Senator MURKOWSKI. Mr. Chairman, if I could just ask one question of Mr. Manley.

Chairman ROCKEFELLER. Sure.

Senator MURKOWSKI. In the Washington State plan, you indicate that you require employers to pay 50 percent of the lowest priced premium offered. If we were to adopt the administration's plan which requires 80 percent, where would you be with your plan?

Mr. MANLEY. Happy.

Senator MURKOWSKI. Well, I know. But wouldn't the Federal conformance mandate 80 percent, so you would pick up another 30 percent?

Mr. MANLEY. I would assume that Washington State would have to adjust its behavior to whatever is enacted nationally. The employers might be less pleased with that approach.

Chairman ROCKEFELLER. Senator Murkowski would insist that I say this, Mr. Manley. Washington State has a lot of rural parts and mostly small businesses. For any business which has 75 or fewer employees, which is probably 90 percent of your businesses—if they are paying, for example, around the minimum wage or slightly above, we have what we call a discount, so that those small businesses would in fact only pay 3.5 percent of payroll for the cost of the comprehensive benefit package. Then our Government would make up the rest, which is what the cigarette tax and other things are for. So it is not like they would go from 50 percent to 80 percent. I don't know if you have any subsidies, but that is the whole point of at least one of the Federal plans, to have very substantial subsidies aimed particularly at small businesses with low wage workers.

Mr. MANLEY. Thank you for clarifying that. I understand the question now. Washington State also has a system of subsidies for the small employer and it is financed by a tobacco and alcohol tax plus a 2 percent tax on the revenues of certified health plans. They, too, are sensitive to the loss of jobs for the small employer.

Chairman ROCKEFELLER. Which I will just say, and, Frank, you can then come back and rebut me here because I am taking advantage. The CBO has made its presence known in the last couple of days around here. I started something called the Alliance for Health Reform about 4 or 5 years ago, which is a nonprofit group; it doesn't promote any plans, it promotes health care. Each of the people who testified before the Alliance—we had experts who are considered conservative, moderate, and liberal—all said, as did CBO, that there would be really negligible job loss, as, of course, was experienced by Hawaii many years ago. I don't think Hawaii gave the level of subsidies that the President's plan is talking about.

Do you want to say something, Frank?

Senator MURKOWSKI. I just want to compliment you on your alertness in responding to a concern that obviously we all have, that is, the subsidies have to come from some place. They don't just come when the leaves come falling down in the fall. [Laughter.] But I think the important consideration relative to the position of the employer is the deductibility of that. If it is 50 percent, is it deductible from State and Federal taxes? I guess we don't know at this time.

Chairman ROCKEFELLER. The answer is, yes, except if it is the Cooper plan, in which case it is not.

Senator JEFFORDS. Depends on the cost of the plan.

Chairman ROCKEFELLER. The cheapest plan, yes.

Senator MURKOWSKI. Mr. Manley said he didn't know about the Washington State plan.

Mr. MANLEY. And I will provide that for the record.

Senator MURKOWSKI. Yes. I would assume that it would have to be. But whether the State portion is deductible, that may be something

else again. But clearly, if it has been approved by the State of Washington legislative body, I assume this matter has been discussed at great length and it probably is deductible. But it certainly is a factor from the standpoint of the burden it puts on the small business, if it isn't.

Senator JEFFORDS. Vermont is on a similar track right now, 50-50. Of course, it is beneficial if the Clinton plan comes in, because then your subsidies from the State go down substantially. The Federal Government or the employers will pick up a higher percentage of the premium and, therefore, the State's cost in subsidies goes down substantially.

Chairman ROCKEFELLER. Mr. Randall.

STATEMENT OF MALCOM RANDALL, DIRECTOR, GAINESVILLE, FL, VA MEDICAL CENTER

Mr. RANDALL. Mr. Chairman, I am honored to appear before this distinguished Committee, which I think has done so much for the cause of American veterans in this country. And incidentally, I understand the concern that you expressed at the beginning of this meeting that there was some implication that we may have been censored by the agency. As far as I'm concerned, that isn't the case. Nobody has tried to tell me what to say or what not to say. So what you hear, whether you like it or not, are my own convictions.

First of all, if I may be so bold, Senator, I would like to remind you that West Virginia University and the University of Florida held one of the debates over health care reform in the Sugar Bowl in New Orleans. I am not certain how the debate came out, but I understand Florida made 41 points, while West Virginia made 7 points during the debate.

Chairman ROCKEFELLER. Your very obscure, Confucian point has been made, to what effect I cannot imagine. But it certainly will count against your time. [Laughter.]

Mr. RANDALL. Florida was one of the first States that moved to do something about health care reform. And VA was one of the early players. The governor asked if the VA Distinguished Physician, who is based at Gainesville, could chair a working group that would conceptualize a health care reform plan for the State of Florida. This individual is Dr. Lee Cluff, who retired as president of the Robert Wood Johnson Foundation and is recognized, I think internationally, as an expert in health care policy. Dr. Cluff did that, and out of that working group, the legislature passed the current plan, which looks an awful lot like the President's plan. It puts in place alliances across the State. In the Florida plan, they are called CHPA's, community health purchasing alliances. It also establishes accountable health plans. The process is very similar to what's found in the administration's plan.

We also were active with the State Government. Once the bill was passed, we spent time working with the new agency that was created, the Agency for Health Care Administration, as the plan was being shaped. I involved the district counsel in the process very early in working with their staff. Kathy Jurado, who is the Assistant Secretary for Public and Intergovernmental Affairs at VA, went with

me to testify before the Florida House and Senate committees on the VA health care programs and the contributions that we were making to health care in the State of Florida, not only in terms of delivery of health care, but in terms of the education and research programs in the State.

In my role as lead director in Florida, I set up a strategic planning committee that has already begun work. Our latest meeting was a 2-day working meeting in which we are developing a strategic plan. First of all, we went through a situation analysis to analyze our strengths and our weaknesses, our opportunities. I might say that the staff director and the minority staff director of this Committee happened to attend some of that meeting and their presence was appreciated. It was a successful meeting. We came out of it, I think, with some objectives and plans that will enable us to move forward.

So I am optimistic. The directors and chiefs of staff in the State of Florida, after we had gone through this strategic planning process, our first effort—they believe that we're in a position to compete successfully in this new health care environment. We believe that health care reform will work. We think we can compete successfully. We can compete based on the quality of our staff; we can compete based on overall hospital quality, as measured by the scores that VA hospitals have made in the last round of inspections by the Joint Commission on Accreditation of Healthcare Organizations, where VA hospitals have outscored the private sector. We can compete on cost; we can compete on our experience in working with a global budget; we can compete because we think that the future is now, not tomorrow, and we feel that we must compete if we are going to make health care reform work and if we're going to ensure the viability of the VA system.

Now, as to the second part of your question. We need flexibility. This has been mentioned before. We simply must have flexibility if we are going to be able to move quickly enough to make changes in this new environment in which we find ourselves. We must change the Byzantine eligibility rules with which VA has struggled for so long. I know that the Secretary of Veterans Affairs has already submitted a proposal to change those rules.

In the words of the real estate experts, there are three factors to consider when buying a home. They are location, location, location. In the case of health care reform, there are three factors central to VA: access, access, access. We can provide access; we've got the mechanisms to do it, we've got the right people who can do it. Just as an example, an idea I picked up. I've been involved in the NIH's Health Scientists Exchange Program in Yugoslavia for some years now. Before that country started coming apart, access to care came through health stations manned by a nurse which were close to the homes of patients. Most people didn't go to a hospital until they went through this very primary care kind of health station. Well, in the primary service areas of many of our hospitals, we can set up these kinds of health stations where many decisions can be made without sending a patient into a hospital. It will mean closer access for the patient, more appropriate treatment for the patient, less waiting time, and it will mean the patient is getting treatment at the lowest

possible cost that is required. It is going to free up the overcrowded emergency rooms in our hospitals. And if we don't set up our own, then we can contract with hospitals and clinics that are scattered all over the State. We do need flexibility; we've got to be able to move.

We do need upfront money so that we can start being bold and start perhaps setting up some of these health stations or entering into new contracts.

Above all else, I think we need the freedom to fail. We have got to be bold, we've got to move, we've got to not be worried about are we going to violate some policy or some regulation. We have got to be free to move.

[The prepared statement of Mr. Randall appears on page 51.]

Chairman ROCKEFELLER. Thank you, Mr. Randall.

Mr. Deters.

STATEMENT OF LARRY E. DETERS, DIRECTOR, NASHVILLE, TN, VA MEDICAL CENTER

Mr. DETERS. Thank you, Mr. Chairman, and members of the Committee. I represent the State of Tennessee here today. I guess going last in this group, there is not a lot new that I can say, but there are a few things about TennCare in the State of Tennessee that I would like to tell you about, and then give you my own observations of what we need.

On January 1, 1994, the State of Tennessee implemented the TennCare Demonstration Project. It is a 4-year project to reform the State Medicaid program and, at the same time, to provide health care to medically indigent citizens of the State of Tennessee. There are three groups of Tennesseans included. The first is the previous Medicaid group, which represents approximately 1 million citizens. The second group are citizens of Tennessee who were uninsured in 1993 and were not eligible for Medicaid, and there is estimated to be 700,000 of those. And finally, a much smaller group of people who were uninsurable because of preexisting conditions or a few other minor reasons.

Many veterans, including many of those who have received their health care from the four Department of Veterans Affairs hospitals and two outpatient clinics in Tennessee, are included in these groups. TennCare may be attractive to these veterans because, as has previously been mentioned, the eligibility regulations of VA allow the State to provide a more comprehensive basic health plan than we can provide, particularly for nonservice-connected veterans. TennCare provides its beneficiaries with preventative health services, doctors' visits, hospital care, ambulatory surgery, and prescriptions within 30 minutes of their home, something that we would have difficulty doing without expanding our services. It also provides these services for the spouse and any dependent children.

It is a capitated, market-driven, managed care system. Managed care organizations, called MCO's, compete with one another to enroll patients from these three categories. On January 1, the 1 million Medicaid recipients were automatically assigned to one of the managed care organizations. During the month of January, they were allowed to switch to the plan of their choice. I might say that there

are twelve managed care organizations in the State, ranging in size from as small as 15,000 enrollees to as large as 300,000, which is Blue Cross/Blue Shield, out of a total enrolled population at this point of 1 million.

The State has kept the total number of non-Medicaid enrollees for 1994 to 300,000, so that a total of 1,300,000 citizens of the State would be covered by the end of 1994. It is the State's hope that additional resources may be identified to allow that cap to rise to cover all 700,000 uninsured Tennesseans by the end of the 4-year project.

There are 521,000 veterans residing in the State of Tennessee. Last year, VA collectively provided care for approximately 14 percent or 74,000. It is too early to determine what the impact of the TennCare program is on VA workload; in other words, how many veterans crossed over from VA to the TennCare program, because the people we're most at risk of losing are included in the group that is being enrolled right now, that 300,000. But we will be able to tell shortly what the impact will be. There are some scenarios involving the shifting that have already occurred. Obviously the larger the number of medically indigent citizens of Tennessee who enroll in TennCare, the greater the opportunity for our veteran patients to choose to leave VA.

The Department of Veterans Affairs' facilities in Tennessee are ready to compete. We provide a very high quality of medical care. We have well-equipped and well-staffed hospitals and outpatient clinics. We have excellent relationships with our veterans organizations, other health care providers, and our patients. We know many of our patients by their first name. That is not true of these other managed care organizations. We believe that we can effectively compete with the private sector and provide the State and Federal Government with leverage to reduce the rapidly rising costs of health care in other places around country because of our size, economies of scale, and our experience in running a large organization of this type.

The President's Health Security Act clearly envisions the Department of Veterans Affairs as a major provider for veterans and their families, and it outlines the necessary legislation in broad terms that we need to allow this to happen. Since Tennessee is moving in advance of national health reform, we are at a disadvantage in this competitive market. Many of our patients are being enrolled with other managed care organizations. Many physicians and group practices in more rural areas are contracting with the other MCO's and are filling up their practices. And the thing that scares me as the person responsible in my hospital for the direction, my competitors are gaining an awful lot of experience during this period through the use of consultants and through actually participating in the plan. I think as more States enact their own health reform legislation or the longer it takes to enact national health care reform, the more disadvantaged the Department of Veterans Affairs will be in States which have enacted such legislation.

I would concur with all of my colleagues that flexibility obviously is what we need. It is difficult to spell out one formula for all of us because, as you have heard, each State is a little bit different. So

when we talk about flexibility, I think we're talking about the ability in each State where we plan to compete to be able to be a full competitor, a full player. If eligibility reform is required, and I think it is in virtually every State, then that is what we need to address. And I think what we offer in each State will be different. Talking about State health care reform, we will match the primary benefits certainly. What we offer additionally as incentives, for example, if we're allowed to enroll higher income veterans in our plans, will be different in every State. We also have those unique situations of living on the border. I have Memphis in my State, which provides services in five different States. So we have quite a few problems to work out in terms of the legalities of signing contracts with other managed care organizations. How do we deal with different States, what do we do with a veteran who comes to us for care from out of State and is covered under a different plan if that State has enacted health care reform? We need contracting authority, as you've heard, the ability to do it more rapidly, and that's certainly true. We need the ability to market the excellent services that we provide. One of the reasons we have had a bad rap, in my opinion, is that we never get to talk about what we do positively. I realize it is the taxpayers' dollars, but I believe if we can be an effective force in health care in this country, we can help provide leverage to you to keep the cost of health care down, because other systems will have to match what we're able to do.

One of the things I did not hear mentioned here is we need cooperation between the Department of Veterans Affairs, between Health and Human Services, and obviously with State Governments in order to pull this off. We are working in the State of Tennessee with our State Government. We were not able to get involved until very late in the game, but I think we had a very significant impact along with the folks from Washington. One example of this: December 14 was our first meeting with State officials, and that was the earliest we could get a meeting with them. After that meeting, a letter was written to HCFA [Health Care Financing Administration] stating that veterans who had received care in a VA hospital during 1993 would be exempted from the TennCare program. Although that would have been helpful to me, it would have helped me keep my patients, we felt it was grossly unfair to veterans, and, as having responsibility for veterans' health care in Tennessee, we notified Washington. The Secretary moved quickly to talk to Health and Human Services, which, in turn, went back to the State, and on the very same day they reversed that decision, so that all veterans who are otherwise eligible for TennCare will not be denied that care because they are veterans. And we were pleased with that.

Chairman ROCKEFELLER. Are you about finished?

Mr. DETERS. Yes, sir. One more thing, startup funds. I agree, certainly.

I appreciate the opportunity to appear before you today.

[The prepared statement of Mr. Deters appears on page 53.]

Chairman ROCKEFELLER. You have all used the word "flexibility," and that is one of those broad words. I am sitting here, Jim, trying to think what does that mean.

Senator JEFFORDS. Same here.

Chairman ROCKEFELLER. Each of you, remember, were given 1 or 2 minutes. We've now been here about an hour, and I took up about half an hour of that, so I plead guilty; but we are running out of time. So let's just really focus. What do you mean by "flexibility"?

Senator JEFFORDS. If I could add one other part to that, the panel could answer all at the same time. Dr. Green talked about special aid or assistance and expertise to help them out. I would like to know what they would need.

Chairman ROCKEFELLER. Besides money.

Senator JEFFORDS. Right.

Chairman ROCKEFELLER. Which I don't think is very likely, do you, from the Federal Government?

Senator JEFFORDS. I heard they were broke, but I'm not sure.

Dr. PETZEL. The combination of a ceiling and a budget are currently inflexible. If we've got a budget, let us spend the budget in any way, shape, or form we feel is necessary to meet the needs of the veterans in our State. That's what I mean by "flexibility."

Chairman ROCKEFELLER. And that's from your perspective. One of you mentioned an inspector general and one of my questions, Jim, on this whole question of flexibility is, are you precluded from taking bold steps and doing things because of the inspector general at the Federal level?

Dr. PETZEL. I don't know who mentioned that, but, for us, it is not the inspector general; it is just the general morass of rules and regulations, which people are working hard to change, I don't mean to imply that they are not. I think these changes will come. It is just that in Minnesota, we need them right now.

Chairman ROCKEFELLER. And what—?

Dr. PETZEL. The most important thing from my perspective is if we've got a budget, let us spend that budget in any way, shape, or form we deem necessary. If we need to hire 100 people to get started doing this, then we want to be able to hire 100 people. If we need to spend $5 million contracting for services in rural Minnesota in order to meet the primary care objectives of MinnesotaCare, then let us do that.

Chairman ROCKEFELLER. And what stops you now?

Dr. PETZEL. Any contract over $25,000 has to come into Central Office and it takes 6 months probably to get it approved.

Chairman ROCKEFELLER. You're kidding. So you are saying that under routine circumstances that's one thing, but if you're trying to move forward quickly, that really hurts you.

Dr. PETZEL. It would be very difficult for us; that's correct.

Chairman ROCKEFELLER. And what is your average when you need to do something?

Dr. PETZEL. In terms of how long does it take in Central Office?

Chairman ROCKEFELLER. No, no. How much money you need. The $25,000, that's a hassle to you. You have got to be able to spend, what, up to $1 million or $100,000, or what?

Dr. PETZEL. Oh. We want to be able to spend a total of between $5 and $10 million on contracting for primary care.

Chairman ROCKEFELLER. And Central Office has said you cannot do it, or they have just said you have to send it to us?

Dr. PETZEL. No. We haven't even asked. The contracting regulations make it very difficult for us to do that.

Chairman ROCKEFELLER. Have you taken them on about this?

Dr. PETZEL. We are having discussions about how to accomplish it, yes.

Chairman ROCKEFELLER. Others, please.

Mr. RANDALL. This is what I was talking about when I said that we needed the freedom to fail. I wasn't talking about the hospital needed the freedom to fail, because obviously we won't fail, we can't fail. But directors and chiefs of staff need a mindset on the part of everybody that's looking over our shoulder—and we have more oversight probably than any organization known to man—everybody that is looking over our shoulder has got to have the mindset to let these people move, turn them loose, let them be bold; let them be innovative and let's not worry so much about breaking regulations and things of this kind. We have to be concerned about breaking the law, of course, because obviously we can't do that. But anything that isn't based on law that is constricting us, we ought to be free to try innovative things that we haven't thought of doing before, without having somebody 6 months later come around and nail you because you did it.

Chairman ROCKEFELLER. Let's just make this an eight-way discussion. Give me an example of something you did and then they came back 6 months later and said that you shouldn't have done it, which then deters you from being ambitious to do things in the future. Give me an example.

Mr. RANDALL. This is a mundane example, but we had a piece of high tech medical equipment and we could have sent one of our own people to the company for training so that they could completely maintain this equipment. But we needed travel money to send that individual. We didn't have the travel money; we went in through the chain of command to try to get travel money. We had operating money that could have been transferred to travel money, but they are two separate accounts and could not be interchanged. So as a result, we couldn't send the man to the company and we continued to pay for contract maintenance that we didn't need to pay for.

But any Federal agency is rife with these kinds of regulations that build up over a few years. All I am saying is that this is a new day, this is a different time, and we have got to try new and innovative approaches and not be afraid that some of our initiatives will fail.

Senator JEFFORDS. As far as eligibility to furnish care, I am a little confused. We have very strict restrictions now. If you are going to have essentially a third-party payer arrangement here, do you need flexibility in your eligibility?

Mr. RANDALL. Yes, sir, we need that badly; we need that badly so we don't have to worry about the man who is service connected for a leg condition and yet they find out he has serious coronary problems; he's not service connected for that, and he is less than 50 percent service connected. We can't treat him for the coronary problems under

our current Byzantine regulations. So we have got to get those straightened out.

Chairman ROCKEFELLER. Are you all frustrated by this? I have a daughter who has started working at the Department of Education here in Washington. After 3 months, she has concluded that it is just a gigantic bureaucratic morass. I believe her. So we keep hearing this and we never do anything, do we. And because they know we're not going to do anything, these agencies just keep going.

Are you all adamant on this? I mean, is VA a bureaucracy that stifles your creativity and your ability to do what you want to do? Is it a basic impediment to your instinct to try something because you just know they are going to come back at you and skewer you, or what?

Mr. RANDALL. I am not just talking about VA, I'm talking about the General Accounting Office, I'm talking about the Congress, I'm talking about investigating committees from the Congress that could come around and second-guess us, I'm talking about the inspector general—I'm talking about all these facets of Government.

Chairman ROCKEFELLER. Give me an example from the Congress. Any of you. Come on, you're under oath. [Laughter.]

Mr. RANDALL. Well, for example, Congress puts the restriction on VA that we can't use operating money for employee travel. Congress constantly lays ceilings, floors, fences around the money that we have, so that it really handicaps our ability to function. I know that all of these things that the Congress does are well intentioned. In many cases, they are trying to ensure that VA receives the money appropriated. But on a cumulative basis, they begin to add up to a heavy weight that you have to deal with.

Chairman ROCKEFELLER. Do you all agree with that?

[General consent.]

Chairman ROCKEFELLER. Do you know what would be very helpful to me, and, Jim, if you want to add on to this—if you would just provide some examples in writing. I will give you my home address, if you want it, or Jim's. [Laughter.]

In other words, just give us examples of the Congress, of VA, of GAO, whatever it is, where you are precluded from doing what in your judgement you need to do. You're out there pretty much by yourself, and then you've got this book staring you in the face saying you can't do it or whatever. You have got two Senators here who would like to try and do something about that.

Senator JEFFORDS. Especially if we're going to design a pilot program here, we have got to make sure we provide you with all the tools necessary in order to make those programs work. The worse thing that could happen is if you become part of a pilot project and then you're so restricted, and we're not aware that you can't do it, and it fails. That would be a devastating impact upon the future of VA in a national program.

Mr. RANDALL. Senator, you just reminded me of an example I couldn't think of when Senator Rockefeller was asking. In contracting, there are so many rules and guidelines to protect the Federal Government, I know, and Howard's point that if he were trying to contract following regular contracting specifications for a physician,

a moose is liable to be the only one that would show up. I asked him if that is how he got his job, is that they contracted him. [Laughter.]

Dr. PETZEL. I wanted to make one point about the contracting. Much of the difficulties we have are in law; they are not a matter of agency rule and regulations, they are a matter of law. That is why the pilot program is so important to us. That will allow changes in the law or exemptions from the law so that we can get on with our business.

Mr. MANLEY. And in defense of VA, they are working very hard. They have made a concerted effort over the last few months with workgroups to figure out what internal hindrances there are, and they are trying to change those internal policies so that we're not doing it to ourselves. A good example, Mr. Chairman, is if I wanted to lease a 2,000-square foot office space-type structure in order to put a doctor and a nurse in a rural environment, that lease would take over a year to be approved. To build something takes about 5 years. But as I said, VA is working to change what they can internally. I think they will be requesting from the Congress those things that they can't change by themselves.

Mr. DETERS. I wanted to add, some of the "reinvent Government" initiatives are underway now that would allow us, if we badly need a physical therapist in a community, to be able to establish the pay for that individual. That would allow us to hire them, rather than having to come in and seek special exceptions to current pay standards. But that is all under review now. I think we will achieve some success here. But again, that is flexibility.

Obviously, in a competitive market, you see what is happening out there and you react to it and you try to react better than your competitors and sometimes you have to be faster. We are not in a position where we can run as fast as most of our competitors. That is such a concern to us that I am afraid we might not even try to make the battle, because we're afraid that we won't have the freedom to compete and we don't want to do anything poorly, particularly health care for veterans.

Mr. RANDALL. I think Mr. Manley has a point. I think since the health care reform debate started, VA has really been making an effort to streamline and to make things easier for us. But they have laws that govern them and that tie the hands of VA in moving.

Dr. GREEN. Senator Jeffords, I would like to address the expertise issue. And realizing that the Federal Government is broke, so is the VA hospital at White River Junction.

Senator JEFFORDS. Right.

Dr. GREEN. In some way the system has to come up with a method, if you will, call it a SWAT team, that will take a hospital that's in the dialogue with the State legislature and bring to that hospital from its own resources the management expertise to advise us. We have had real help in the Vermont health care dialogue from Ms. Pat O'Neil, who is sitting in the background there, who did come and testify to the legislature. But we really do need people and experts that know what's going on in managed health care, on how to do risk assessments, on how to deal with a capitated population. Because the

population that we currently serve cannot be capitated at the same rates as a population that mixes sick with well.

In short, the HMO's have made their money by skimming the population, and we aren't in that position. The Vermont Hospital Association has basically told us up front, we don't want the patients you are currently serving because they are very high cost patients. They are not going to fight us over that issue. But the minute we get into the business of marketing to the spouses, to the well-heeled veteran population, they immediately have a different story. So we've got to have the expertise to analyze the population needs so that we get a fair capitation for those that we're going to serve. If we can distribute the population between the well and the ill, then it may be that a capitated amount, a universal capitation adjusted to that population would work, and actually that's included in some of the plans in Vermont. As you know, they are very sensitive to the capitation issue. But we've got to have that expertise available to us and we don't have it locally. And that's the truth.

Chairman ROCKEFELLER. How many of you think that you can have universal health coverage, with every single person in your State being covered by the year 2000, if the Federal Government does not require that to take place, you simply proceed to do it on your own as States?

Dr. PETZEL. It is the stated goal in Minnesota to do that. I believe that they will accomplish it.

Chairman ROCKEFELLER. You think you can do it without the Federal Government?

Dr. PETZEL. Yes, I do.

Mr. DETERS. It is the State of Tennessee's goal also, but I have certain reservations myself about whether enough dollars exist. I think we will know by the end of the year.

Mr. MANLEY. The commitment is there in Washington State. The health care community is behind it, as well as the business community. I think managed competition is still a theory, and it is hard to know whether it will actually work when it is put in place. But I think if anybody can do it, the folks out there can.

Dr. GREEN. In Vermont, my estimate is that it is possible. I think the financing issue is a big thing in Vermont. It is based on a series of taxes and employer contributions. It is a populist State, and if any State in the Union has a chance of getting there, I think Vermont is a good candidate for that.

Chairman ROCKEFELLER. I think I would agree with that.

Mr. RANDALL. And I think Florida has a commitment, if any State does. On the other hand, someone said that health care is local, and I think which special interest groups are the strongest in the different States will determine the outcome of the health care, unless there is some kind of standard that sets the standard for all States.

Senator JEFFORDS. Let me ask you a question now and how you would envision it under a pilot project. What happens to third-party pay money now? Where does that go?

Dr. GREEN. You mean that we collect?

Senator JEFFORDS. That you collect.

Dr. GREEN. That is collected by the so-called Medical Care Cost Recovery program operation within VA, and that goes back at some point to the Federal Treasury after expenses are taken off.

Senator JEFFORDS. My point is, if you are in a pilot project and you get rather large sums of third-party payer money from the State, capitation payment, whatever else—we have got to provide something to make sure that it stays with you in order to be utilized in your budgets, right?

Dr. GREEN. I think you have to distinguish, Senator Jeffords, between—and I may be stepping out of my bounds—a primarily eligible population of veterans, meaning service-connected and poor veterans, and what is collected in the Medical Care Cost Recovery Program now for that group, versus a population of veterans who can use the system if they bring external money in. Clearly, we can't serve them with appropriated funds. So, therefore, obviously we would have to keep the money that came from whatever paying alliance, whether it be a State or multiple payers or whatever, in order to serve them, because our budgets would preclude us doing so.

Chairman ROCKEFELLER. Final question from me. Under the law the way it is, VA medical facilities provide inpatient medical care to veterans with any service-connected disability, even a zero percent disability. However, only veterans with a 50 percent or greater disability rating have access to comprehensive outpatient care. How many patients do you serve every year who are less than 50-percent disabled and would therefore qualify for more outpatient care under health care reform than they currently receive?

Dr. PETZEL. I'll start. It is a little bit misleading, in that we're mandated to do that; we are allowed to do more if we have the resources available to do it. In Minneapolis, we do take care, in the outpatient arena, of veterans who are less than 50-percent service connected. But we have discharged a number of high income, what we call Category A veterans, and that amounts to about 5,000 people that we think with eligibility reform might be eligible for a more comprehensive outpatient program than we're now offering them.

Mr. MANLEY. We also try to provide that full outpatient care to those veterans who can get to our hospital. It is not unusual in Washington State for our patients to come up to 300 miles for an outpatient visit. The difference under universal coverage is that we would have to take that care to them so that they are not travelling more than 15 or 30 minutes from their home to get it. The veteran population is about 646,000 people in the State. So the bigger question is, how many of those would elect us if the care were available at the same level that the private plans provide. I have no idea how many of them might do that, sir.

Dr. GREEN. Senator, we have a similar situation as Dr. Petzel. We do not deny veterans below 50-percent service connection outpatient care. We consider them primarily eligible veterans. We do limit care to that broad group of veterans that fits within Category A by income, and we do not have very many people that we serve above the income limit specified by the regulations.

Mr. RANDALL. On the outpatient side, 90 percent of our patients are in the mandatory category, and of that 90 percent, 62 percent are

service connected. On the inpatient side, 98 percent of our discharges are in the mandatory category, and of that number, 47 percent are service connected.

Mr. DETERS. On the inpatient side, it is 82 percent are mandatory, that is category A or service connected. On the outpatient side, it is 98 percent are mandatory. So we are doing what you said on the outpatient. You asked about those who are 50-percent or more service connected. I am using my own hospital's figures rather than the statewide figures, but it is 17.4 percent are 50- to 100-percent service connected, 23.5 percent are 0- to 40-percent service connected. That figure is slightly higher on the 0- to 40-percent for outpatient; over 50 percent of the people are service connected on the outpatient.

Chairman ROCKEFELLER. OK. You have all been very helpful, and I appreciate that. You have come long distances, and I appreciate that. Mr. Manley and Mr. Randall, you have come a particularly long way and I appreciate it a lot, as does Senator Jeffords. Thank you very much.

Chairman ROCKEFELLER. Our second panel consists of officials from the Department of Veterans Affairs. We have Dr. Elwood Headley, who is the Director of the VA National Health Care Reform Office, accompanied by the general counsel, Ms. Mary Lou Keener, and Ms. Karen Walters and Ms. Pat O'Neil, also from the Program Office. Your testimony will be submitted and included in the hearing record. But given our time constraints, I would like to proceed with our questions. As you know, we are receiving sworn testimony today. Please raise your right hand.

Do you swear that the testimony that you give will be the truth, the whole truth, and nothing but the truth?

Dr. HEADLEY. I do.

Chairman ROCKEFELLER. Let the record reflect the question was affirmatively answered.

First, I would like, Dr. Headley, for you to tell me specifically what impediments exist in current law that would prevent VA from participating in health care reform in the States. Please be as specific as you can.

STATEMENT OF ELWOOD HEADLEY, M.D., ACTING DEPUTY UNDER SECRETARY FOR HEALTH, AND DIRECTOR, NATIONAL HEALTH CARE REFORM OFFICE, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY MARY LOU KEENER, GENERAL COUNSEL; KAREN WALTERS, DEPUTY PROJECT MANAGER AND DIRECTOR FOR POLICY AND LEGISLATION; AND PATRICIA O'NEIL, SPECIAL ASSISTANT TO THE ASSISTANT SECRETARY FOR POLICY AND PLANNING

Dr. HEADLEY. Yes, sir. Before I begin, I would like to just say that I was distressed by your initial remarks regarding the late arrival of testimony. I am not aware of, nor do I believe that it was related to, attempts to censor testimony here today. I will take this message back. I am sorry about this. We will work to see that it doesn't happen in the future. We need to have a collaborative relationship based on trust.

I think there are a number of things that impede our ability to effectively compete in the States. We have been looking at these and working with the States since October, 1993, when Secretary Brown started the National Health Care Reform Office with the States' initiative as a part of that office.

In working with the States, one of the first impediments that we faced was a lack of knowledge on the part of the State legislatures and a lack of input into the process from VA staff in the States. This was one of the first things that we identified and we began a process to work with the leadership of VA in the States and to encourage them to participate with the State legislatures in the development of health care reform. We provided them information about dealing with the States. Ms. Pat O'Neil and Ms. Kathy Jurado, the Assistant Secretary for Public and Intergovernmental Affairs, have visited with many of the States who are very active in health care reform, to work on this process. One of the first things that we identified and worked on was getting us involved with the States so that the unique contributions that VA has to offer in the States would be appreciated and so that we would have an attempt, before legislation was formulated, to have some input.

Chairman ROCKEFELLER. Dr. Headley, what I asked you was what impediments exist in Federal law.

Dr. HEADLEY. There are several, and they have been identified here today. These are the same impediments that we are recommending in the pilot legislation which will be submitted to Congress in the very near future. First is difficulty with eligibility. We need to be able to deliver care across the board to people for whom we care. We need to be able to deliver the comprehensive benefits package. In our current eligibility structure, we are unable to do this. This is addressed in H.R. 3600, President Clinton's Health Security Act proposal. It also will be addressed in our proposed legislation for pilots.

Another thing that has been identified here today and which exists in law, although it is very complex to ferret it out, is lack of flexibility on the part of local managers in terms of personnel issues, and in terms of contracting, which also has been identified here today. The ability for local facilities to enter into contracts and to deal in different ways with personnel issues are major impediments to our ability to function.

Chairman ROCKEFELLER. Can you afford to do eligibility reform without more money from the Congress?

Dr. HEADLEY. That's a very difficult question. It depends on how it is approached, whether or not it includes families and dependents. We probably could not in some States. It depends on the packages in the States. I think that we would have to analyze these, but in general, I think that there probably would be some need for additional funding for the pilots.

Chairman ROCKEFELLER. For awhile now, VA has lacked the funding needed to buy medical equipment and build or renovate medical facilities. In the proposed VA budget for fiscal year 1995, there is a substantial cut in funding for capital improvements. Does that have an effect on your being able to compete?

Dr. HEADLEY. Once again, this is a very difficult question to address in its entirety. It is not at all clear under health care reform exactly what we will need in terms of capital outlay. It is anticipated that as we go about health care reform, we will be engaging in more building, renovation, or contracting out decisions. And we may be doing less building, we may be doing more sharing, we may be doing more contracting for services and less capital construction.

Chairman ROCKEFELLER. The first panel expressed, I think, some sense of urgency about the need for VA to conduct a pilot study in their several States. The quickest way to do this would be to pass legislation that gives the Secretary broad authority. If you can, I would like to have you give us several concrete examples of how much of that authority the Secretary would be willing to transfer to the VA officials in the States involved if given broad discretion by us. For example, would VA Central Office (a) be willing to give each State facility autonomy to enter into contracts for services that would not be reviewed by Central Office, and (b) be willing to give local VA managers the autonomy to determine how to implement some kind of eligibility reform in their State, or would that issue be determined by Central Office?

Dr. HEADLEY. Once again, I would hesitate to speak for the Secretary. I think that we are trying at the present time to develop ways to allow these things to be done at a local level, to decentralize many of these decisions. I would find it difficult to deal with this in a very specific way at this point in time.

I might ask Mary Lou Keener if she would like to comment on the contracting.

Chairman ROCKEFELLER. Before she does that, you said that you are doing a variety of things to try to decentralize. What did you mean by that?

Dr. HEADLEY. Well, in terms of planning for health care reform, we have been considering ways to decentralize the way that we organize and run facilities. It is premature to talk about some of these things. I am sure that you've heard of VSA's [Veterans Service Areas] and the concept of decentralizing control to some degree more peripherally, and I think that legislation regarding this will be requested in the near future. But in terms of planning, we have been looking at ways to decentralize control to the local level. The pilot that we are proposing is one way to do this on a limited basis.

Chairman ROCKEFELLER. You're thinking out loud there, but you haven't given me concrete examples of what you are doing to decentralize.

Dr. HEADLEY. I am unable to do that at this point in time. I don't really—

Chairman ROCKEFELLER. Just think out loud for me then—you don't have to speak for the Secretary; well, yes, you always speak for the Secretary, but everybody takes risks. What would you allow the State to do, what would you not allow the State to do in a world if you could construct it right now within the next 3 minutes?

Dr. HEADLEY. I think that one of the things that we have been talking about, and this is certainly not in a proposal form at this

point in time, is to decentralize contracting authority to a more local level.

Chairman ROCKEFELLER. Does that mean the amount would go way up, or that they would just generally do it, or what?

Dr. HEADLEY. That they would just generally do it. That we would attempt, philosophically attempt, to decentralize these decisions to the level at which the decisions had to be made. There would be standards set and then local stations would be allowed implementation.

Chairman ROCKEFELLER. So that in a sense, the $25,000 limit which they all referred to strikes you as maybe not useful.

Dr. HEADLEY. To the best of my knowledge, that is regulation that is based in law.

Chairman ROCKEFELLER. By us.

Dr. HEADLEY. To the best of my knowledge, yes. And it is not helpful and is an arbitrary limit. I think that we need to allow people the flexibility to do what they have to do.

Chairman ROCKEFELLER. Point well taken.

Mary Lou Keener.

Ms. KEENER. Mr. Chairman, I might just add that, as you know, Dr. Headley has been heading up the Health Care Reform Office at VA for several months now. The cluster groups have been meeting and the working groups have concluded their meetings and discussions. The Program Office is now in the process of putting together those recommendations to bring them to the Board of Directors who will then look at them and take them to the Secretary. Part of those recommendations, as I understand, that will be coming to the Board are intrinsically involved with the concept of empowerment, meaning that everyone in the Department seems to be of the same mind that it is extremely important that the field and the individual medical centers have the power and authority to do the things you heard them talk about today.

We are looking at that on two levels. The cluster groups and the Project Office will be bringing their recommendations to the Board from which will evolve the VA plan for health care reform. At the same time, we will be making legislative efforts to empower and assist the people in the medical centers in obtaining the authority that they are telling us they need to have.

So, in response to your first question, what kinds of statutory relief do we need, we will need the kind of authority that is encompassed in the President's health care reform bill, and which will also be spelled out in detail in our State health care legislative package. We need the legislation over here to relieve those statutory constraints that these folks have to operate under. And then, from an internal departmental policy perspective, we will have the health care reform plan that the Board and the Secretary will be looking at in about 3 weeks.

Chairman ROCKEFELLER. In the fiscal year 1995 budget, the President proposes a cut of 3,700 VA health care employees. This would be hurtful for a medical system that is trying to gear up for health care reform. I am not sure that you can answer this, but I'll just ask it. Have you thought about what you do about that?

Dr. HEADLEY. Yes. There are several ways in which we have been thinking about this. First is to decrease the percentage of personnel cut from patient care activities and to focus cuts in nonpatient care activity areas, although I don't think that will answer the entire issue. The other has to do with contracting. We don't really know at this point in time how many people we will need on our payroll in the next 2, 3, 5 years. As Dr. Green pointed out, I think it would be relatively impossible for us to hire in Vermont, or in many markets, people in VA who will deliver care to our patients. On the other hand, I think it will be possible for us to contract out to buy that care from other providers in the communities.

I think that as VA goes into health care reform, like other health care providers entering health care reform, there will be massive needs to combine, to enter into sharing agreements, and to consolidate laboratories and other diagnostic testing facilities, to consolidate care facilities, and I think that the impact that this will have on our need for personnel, for FTEE, is unknown at this point in time. So it is very difficult to say.

Chairman ROCKEFELLER. Ms. Keener said this week that VA has authority to contract out services.

Ms. KEENER. Yes, sir, I did say that. That comment was specifically in reference to the FTEE cut contained in the President's budget. Our interpretation of the statute [38 U.S.C. 8110(c)] indicates that if we are required to make the FTEE cuts that are currently in the budget and to operate in 1995 on the resources in that budget, it will be necessary in some cases to do so with fewer people. If we have to do with fewer people, then there may be some services—both direct patient care and nonpatient care services—which we will not be able to provide because of this required cut in the budget. Should that occur, we would have the authority, under 38 U.S.C. 513 or 7409, to allow the Secretary to go ahead and contract for those services. That's the rationale for our opinion on that particular issue.

Also, Mr. Chairman, if I might just add something that I think is important here. You talked about funding. I think it is important to recognize that in the President's health care reform bill, if and when that passes, we have been given $3.3 billion that will aid us in startup costs. In the interim, regarding the State health care legislation, we were notified yesterday afternoon by the administration that the administration is going to work with us to provide some funding mechanism for the State pilot projects. We anticipate that legislation with some specific funding pieces in it will be ready in 2 to 3 weeks.

Chairman ROCKEFELLER. So that might be good news then for the States.

Ms. KEENER. Yes, sir, that is very good news, because we were not aware of any commitment by the administration to fund the State health care legislation projects. So we were delighted to find that out yesterday afternoon.

Chairman ROCKEFELLER. Good. How do you decide which States you want to include in a pilot study?

Dr. HEADLEY. We have not made that decision yet. The way we plan to go about it is that we have identified the States that are

particularly active in terms of health care reform legislation, and we have been working with the directors in these States. We have asked them to start thinking about the implications of the health care reform that their State is working on or has passed relative to VA. As soon as we get health care pilot legislation, we will go out with requests for proposals to the most active States and make the selection based on the response to those requests for proposals.

Chairman ROCKEFELLER. Some States are active or geared up, and some States aren't that way, but a pilot project could still be useful.

Dr. HEADLEY. Absolutely. And we would consider them as well. We will go out with a request for proposal to all States.

Chairman ROCKEFELLER. OK. Is there anything more that you want to say, Dr. Headley?

Dr. HEADLEY. No.

Chairman ROCKEFELLER. OK. I thank you very much.

Dr. HEADLEY. Thank you.

Ms. KEENER. Thank you, Mr. Chairman.

[The prepared statement of Dr. Headley appears on page 54.]

Chairman ROCKEFELLER. Our third and final panel will provide a broad overview of the potential impact of State health care reform on VA health services. John Bollinger is the Deputy Executive Director of the Paralyzed Veterans of America. PVA has done a very impressive analysis of State reform activities, and we are very fortunate to have him here today with us. Also here today is Dr. Tom Garthwaite, who is getting to be fairly familiar here. Dr. Garthwaite, I am grateful that you're able to testify today on behalf of the National Association of VA Chiefs of Staff. I would also like to thank both of you for the timely submission of your testimony. Now I have to put you under oath too. I am most displeased by this whole process, but we will do it.

Do you swear to tell the truth, the whole truth, and nothing but the truth?

Mr. BOLLINGER. I do.

Dr. GARTHWAITE. I do.

Chairman ROCKEFELLER. Good. Have the record show that both answered in the affirmative.

We are asking you, perhaps unkindly, to limit your testimony to 5 minutes. John, why don't we start with you?

STATEMENT OF JOHN BOLLINGER, DEPUTY EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. BOLLINGER. Thank you, Mr. Chairman. I will attempt to be brief. First of all, thank you for inviting PVA to testify today. As Mr. Randall said earlier this afternoon, the future really is now for the VA medical centers that are located in the States that are implementing health care reform or that are considering health care reform in their States.

Before I begin, let me emphasize how very deeply PVA is concerned about the issues before us today. VA's ability to provide quality health care programs and services is something that literally affects every one of our members every day of their lives. From wheelchairs to other prosthetic services, these are things that we have come to

rely on and we need to know that VA is there and we count on VA every day of our lives.

Several years ago, PVA began a project called Strategy 2000 which addressed the issue of VA's role in national health care reform. We realized at the time that many States would try to tackle the growing national health care crisis by moving ahead with their own versions of reform. As a result of our concern as to what would happen in each State, we established a State health care reform project to monitor State reform activity in all fifty States. Much of the information we've gathered has been sent to you, including this January 1994 document entitled "State Health Care Reform Efforts."

One of the most glaring and consistent themes that has run throughout this study so far has been that States, for the most part, have ignored VA as they consider health care reform.

Chairman ROCKEFELLER. That is really true, isn't it.

Mr. BOLLINGER. It is, sadly. And for a variety of reasons, including confusion over eligibility rules, States are considering plans that would seriously jeopardize VA's role, either by enticing large numbers of veterans out of VA into State programs where they would receive enhanced benefits, or by precluding veterans from the State system on the false assumption that all veterans receive all the care they need through VA. We believe we must begin at the very least with an enhanced awareness of the contribution VA makes to every State—taking care of the medically indigent, providing training resources for health manpower, sharing agreements and affiliations with universities, and much more.

Mr. Chairman, I was prepared to talk to you about all the things that I think Congress could do to help the States with these pilot programs, but I think it was pretty well covered by the gentlemen from the State VA medical centers. So I won't go over that whole list. But let me say that I think flexibility is very important and I think I agree with the definition of flexibility that we heard today. Obviously, comprehensive health care is absolutely necessary, entitlement reform, and we have been saying that for a number of years. VA needs to establish community-based outreach clinics. And they need to be able to provide service for family members; we feel very strongly on that. These are the things that we believe the Congress needs to do to make this work.

We have also identified a number of areas of concern in the process of designing pilot programs for VA's interaction in the States. First, we are very concerned that as VA facilities get the authority to offer the basic benefit package, they will be enticed to shrink that package to the lowest common denominator with the States in order to compete. As a result of the drive for cost containment and fewer appropriated dollars, it will be very tempting for VA to abandon those very services that they do so very well now, like spinal cord injury care, blind rehab, and several other health care services. This would be a tragedy for veterans who look to VA to receive this unique care.

Next, determining how eligibility for benefit packages within the pilot program service areas also needs to be addressed. Just briefly in summary, we would suggest that eligibility be established based

on traditional service areas, as opposed to geographic or State boundaries.

Finally, if pilot programs are established in the States, where will the funding come from for these projects. In preliminary discussions, we have heard a call for VA to utilize funds in the medical care or construction accounts. Mr. Chairman, on Monday we learned that the administration has recommended only a $500 million increase for fiscal year 1995 for VA's medical care account. This increase, in addition to the reduction in FTEEs, if accepted by Congress will, I believe, devastate VA's ability to provide quality health care as we're talking about today. In past years, the administration has given VA billion dollar appropriations for their health care account, just to keep their heads above water.

I must tell you that I get a little nervous when I think about the message that this conveys to us when we sit here and talk about quality care that the States will be able to provide in these pilot projects. Quite frankly, I just don't think it is going to be able to work unless they get all these things we talked about today, plus the funds to carry it out. For that reason, we would urge you to provide separate appropriations in the nature of a grant program that we have discussed in the Independent Budget that we will be providing you in the very near future.

If VA is able to successfully compete with States which have implemented health care reform before the national health care reform package is enacted, I think VA will have taken a giant step toward ensuring its viability in the future. We hope that it is given a serious chance to do that. Thank you.

[The prepared statement of Mr. Bollinger appears on page 58.]

Chairman ROCKEFELLER. John, let me just share a thought with you. The FTEE and the funding that you are talking about is a direct consequence, of course, of the so-called Deficit Reduction Act package, which the people of America and the people of this city, pundits, et cetera, said that we would never be able to do. I think President Clinton, to his great credit, bit that bullet, and I think Congress, to its whatever credit, also bit that bullet, and now we are in the process of the cuts. So that's number one; this was sort of a central core of how do you help make America stronger for the longer run. I think we all know the difference between what you get in the short term as opposed to what that does in the long term.

But what I really want to mention—and it's something that I haven't done a very good job on because we've been out on recess and everything. I can do it here safely because none of my colleagues are here, and many of them disagree with me on this, which is startling to me. What really concerns me is the so-called balanced budget amendment which comes up for a vote on February 22, as soon as we get back from our recess. If that bill goes through—and there are many on both sides of the aisle in this Committee who are currently for that—you can forget health care reform; you can forget it. You can have health care reform to a greater extent, I think, in this country, or you can have a balanced budget by 1999, but you surely cannot have both. That is not a speech directed to you, John, because you

know that better than I do, but since I am unattended by my colleagues, I have the freedom of the pulpit here.

I hope that the veterans service organizations are on to this. The recess is going to be very, very important. And on the House side, as you know, this passed overwhelmingly last year or the year before. There are Senators who are for this who are for it because they have said that they were for it in past years and never thought it would actually come to pass. You know what I mean, one of those things where you can sort of tell your local Rotary Club that oh, yes, I'm for a balanced budget amendment, but you know in the back of your head it will never happen. Well it is going to happen unless we beat it.

Now this is outright political propaganda here on my part, but I feel very strongly about it, because you can take the VA health care system and forget that, you can take national health reform and forget that, you can take the integration between the two, you can take the entire thing—

Mr. BOLLINGER. Somehow I think I better answer this question the right way. [Laughter.]

Chairman ROCKEFELLER. You don't have to answer it because I know the way you feel. But it is extraordinary to me that before Christmas, there were 61 Senators who were flat out committed to passing a balanced budget amendment and 6 who were leaning heavily yes. That is 67 and that is all it takes. The President doesn't have anything to do with this, he could be for it or against it, it doesn't make any difference. He doesn't touch it. It goes right from the Congress to the States. I guess it would take the States about a month for the 34 or 37 of them, whatever it is required, to pass it.

You talk about veterans' health care devastation, that is it. This is kind of a stealth thing. Paul Simon, who is leading this charge—he's a Democrat, feels the country can't survive without it. Fortunately, he allowed George Mitchell to postpone the vote until February 22, rather than having it before the Christmas break. If he had called for it then, I think it would have passed. It's the most devastating piece of legislation I've ever seen.

So you don't have to say a thing, John.

Mr. BOLLINGER. Well, if the administration and the Congress are serious about preserving VA, and we are told that they are, without the equipment backlog being taken care of, without the funding that the States are going to need to compete in State health care reform, and without additional funds for direct patient care, VA is not only going to shrink, it is going to collapse. In good circumstances, with a generous benefit package on the part of national health care reform, with little or no copayments, with the appropriations that we have been accustomed to, with the perception of VA hospitals, and with the convenience of VA hospitals, all these factors enter into it; and even if those things are handled well, there are still going to be a number of veterans that are going to leave the VA system primarily because of convenience and probably because of perception.

The VA system is going to shrink, but it has got to become lean and mean. What we want to be sure to prevent is that it doesn't disappear all together. We need the spinal cord injury centers that

are out there, we need a strong tertiary health care system to support that, and we think that can be done if we get a true commitment from the administration and the Congress.

Chairman ROCKEFELLER. Are you going to be out there working in the recess against this balanced budget amendment?

Mr. BOLLINGER. We'll do that.

Chairman ROCKEFELLER. I didn't mean to pick on you, John, but it is something that has been bothering me. It is kind of a stealth thing that just moves along, and the day gets closer and closer, and then all of a sudden it is just a few days away.

Thank you.

Dr. Garthwaite, I apologize to you for this delay, sir. I would be happy to hear from you.

STATEMENT OF THOMAS L. GARTHWAITE, M.D., CHIEF OF STAFF, CLEMENT J. ZABLOCKI VA MEDICAL CENTER, MILWAUKEE, WI, ON BEHALF OF THE NATIONAL ASSOCIATION OF VA CHIEFS OF STAFF

Dr. GARTHWAITE. Mr. Chairman, I would like to thank you for this opportunity to take the risk of testifying today. [Laughter.] I won't insult you by reading my written testimony or oral testimony since I don't think there is anything in there, save one point that I'll make in a moment, that is different from what others on the first panel have said.

I do think it is important that the pilot projects be granted to any State with legislative changes. It would be very hard to go into negotiations with a State about health care reform and the role of your medical center if you had no assurance that you would be able to perform once the legislation went through. So to limit pilots to a few States would cut off all the others from negotiating, and I think that would be a mistake.

Vice President Gore has instituted a "reinvention of Government" campaign, and the Milwaukee VA medical center has been fortunate enough to have been selected as a reinvention laboratory. I can't tell you how positive and how invigorating that has been for our medical center and for our staff. The main message is that they are willing to listen and to change centrally. So that we now have the confidence to look for the barriers in our own minds to reinventing our hospital. I think that is a real exciting part.

Another part of the Vice President's package that I've seen recently was his opportunity to present his "Top 10 list" on the David Letterman show. You asked a previous panel to give examples of needed flexibility. I have ten specific things where congressional or VA Central Office flexibility would be important.

One of the areas has been in eligibility. We can remove veterans' cataracts on an inpatient basis for Category A veterans who are not service connected for their eye disease, and we can provide the glasses they need postoperatively. It costs us about $3,500 to do that. Alternatively, we can do the surgery on an outpatient basis and provide the glasses for less than $1,000. The law only lets us do one of those; it only lets us bring them in the hospital. So we're asking

our employees to do something they don't do in the private sector and that, we feel, is silly.

We are given FTE ceilings and we're given an amount of money in personnel accounts. We must try to hire people in a proper mix to play the game so that we come out with the right number of FTE for the year and spend our personnel dollars. We play that game without the assurance that we will have the same resources next year. We can't commit for a long period of time, so we put on temporaries at the end of the year to do jobs that are needed but are not our highest priority because we don't have the confidence going into next year our FTE is going to be the same. Since we can't RIF FTE's, we have to take FTE cuts where it hurts the most, where we have turnover. Typically, turnover occurs in our nursing personnel and in our clinic and ward secretaries. So these are the places that always gets hurt the most, and they are among the most essential parts of our operations.

The third area where flexibility is needed is in personnel regulations. For example, the way we pay physicians doesn't reward performance, it really rewards seniority. It doesn't say if you work harder, you get ahead; it says if you can hang around longer and you have certificates to hang on your wall, you get ahead. But it doesn't say that if you perform better or if you provide more primary care or if you answer more phone calls in the night, we will reward that. As a matter of fact, routinely we don't even look to find out the people who do these things. We try to do that in Milwaukee.

Chairman ROCKEFELLER. And you're doing it in Milwaukee with some success?

Dr. GARTHWAITE. I attempt to estimate our physician productivity based on RVU's, resource value units that Medicare would use, to get an assessment of whether we have the distribution of physicians properly and if we're getting our money's worth. The reality is that we get our money's worth. My analysis would be that it would cost us probably $8 million more to hire our physicians under Medicare reimbursement alone. The only reason that we can hire them more cheaply, I think, is the academic environment and our ability to have residents and provide teaching and research. So, for a small investment in research—our budget from VA is probably around $4 or $4.5 million—we are getting an additional $8 million in health care. If you took away the research, we wouldn't get the research done, I couldn't give you the quality of physicians because at Medicare rates I would be lucky to hire anybody. So I can give you high quality physicians and research and it's cheaper.

Another area where I think we have things backwards is that we tend to hire people and promote them for service to the bureaucracy, not service to the patient. A secretary who enters VA and does a great job welcoming patients and provides a wonderful environment has one way to get a raise, and that is to leave what he or she does well and go to work for a service chief or the chief of staff or the director. So the thing we appear to value the most is service to the bureaucrats, if you will, rather than service to the veteran.

Chairman ROCKEFELLER. Please explain to me what you mean.

Dr. GARTHWAITE. Well, basically what happens is that the higher paying positions open up and everyone in the medical center can compete for those. If your secretary vacancy is open, you pick the best person you can find. Typically that draws out of our clinic secretary pool so that the best, the brightest, those who have provided the best interface with the public, if you will, are the ones that constantly get drained off, which means we now have to train new entry level people. So it is a constant training ground. It is just the way the rules have been set up and the way the personnel regulations are written. I am not sure exactly where you have to turn that one around, but I do think it is important if we really believe that our job is service.

I would also argue that the funding for VA overall is too low. There has been at least one study that I am aware of that tried to compare the amount of money that we put into health care versus what Medicare would put in for the equivalent amount of health care by using DRG's [diagnostic related groupings] for admissions to hospital. It suggested that we would get about what Medicare would provide for just the inpatient, nonphysician component for inpatient stay. There are very few hospitals that survive on that alone. As a matter of fact, I think the Clinton plan would provide a basic rate higher than Medicare alone. Regardless, there are very few hospitals that survive, certainly none that thrive, on Medicare reimbursements alone.

What we're left with is trying to take a fixed budget allocation and use those flexible eligibility rules to deliver as much good care as we can.

Another significant area where I think we could use flexibility has to do with our oversight and inspection. Anyone seems to be able to come in and inspect a VA hospital. We were inspected 3½ years ago by a nurse whose credentials were not reviewed by us or, to my knowledge, anyone else, who released all the information first to the press. There is probably no way that we will ever overcome the negative publicity that she caused. Positive publicity about your hospital is very hard to come by; negative publicity gets the front page, a lead story, all the sound bites. We were killed. The reality is we were picked by mistake. It was a computer error, the wrong code was put in. So even if the study had been valid, we were picked by mistake. To succeed in a competitive environment, we can't have an antimarketing force against us.

Chairman ROCKEFELLER. Are you saying that she was giving out information about a hospital that was not your hospital?

Dr. GARTHWAITE. It was just a wrong code was entered. The code was for heart valve surgery with death, not cardiac codes with death. But it was reported as cardiac codes with death and we were included in a group that we otherwise wouldn't have been included in. But the whole point I am trying to make is that I think we really need to make sure that if we're going to publicly inspect VA hospitals, that we do it at the highest quality level. I can't hire a surgeon and allow them to operate without primary verification of their credentials to perform surgery. I don't think that we should demand any less of the people that we allow to inspect us, because there is no coming back from incorrect criticism.

Chairman ROCKEFELLER. That probably applies to visiting politicians, too. [Laughter.]

Dr. GARTHWAITE. Can I take the "fifth?"

Another area of flexibility is in purchasing. We are only allowed to spend most of our project and equipment money in the fourth quarter. I understand the fiscal realities of needing to do that because it is better for the country to expand the national debt later in the year. But the impact of that on the medical center and the staff who have to buy that equipment and obligate all those funds in the last quarter and last month of the year is enormous. It costs in overtime and it gives out a strange message to your staff.

The research appropriation every year seems to be something that has to be fought for. It continues to send a message to our researchers that we're not sure if we want to do research in VA. So this one carrot that I can hold out to get great people to come to the medical center and deliver health care—you are not sure whether the carrot is there. Having a lack of commitment doesn't discourage everybody; really, it is only the people with options who decide that that isn't good enough for them, but those are exactly the people that you want to get and retain.

Chairman ROCKEFELLER. That's really a very interesting point. That is a battle that we fought last year and we were successful. So our point of view is that we were successful. Your point of view is that because we had to fight a battle to maintain it, that's the message that gets heard by the physicians.

Dr. GARTHWAITE. I think the message ultimately was great. I think that there was a great sigh of relief. But if every year the battle is fought—

Chairman ROCKEFELLER. Yes. That's a very, very good point.

Dr. GARTHWAITE. And these are bright people. You are really talking about Ph.D. and M.D. researchers who have basically made a choice between the academic environment and a lower salary, versus going into the private sector and trying to generate money. They tolerate a significant salary differential because of their love for research and science and teaching. It is those people that make VA a wonderful place to work. I hate to keep giving them a negative message.

The final thing that I might point out on my short list of needed flexibility is that we seem to think that "computer" is a dirty word in VA. I don't know whether that is because of the complex problems of trying to develop a system versus buying it in the private sector, or whether there is a sense that if you spend money on computers you are not spending on health care for veterans. The reality is that computers are becoming an even more integral part of patient care. We don't debate whether to get another ultrasound machine or another CT scanner or another MRI scanner; it is accepted as part of what we need to deliver health care.

Getting information to the right people at the right time has become so critical to delivering health care that I call computers the "stethoscope of the 1990's." It is an essential tool and it is becoming more and more of an essential tool for us to deliver care efficiently and well.

I believe strongly that the most fundamentally important thing the Federal Government can do in health care today to affect how much we pay in the future is to standardize how we collect medical information, so that the private sector can work off of that standard to develop the software routines that will allow us to get more efficient. If you really think about where we spend money in health care, we spend a lot of money pushing paper around trying to decide whether we should or should not do something, getting OK's to do it, doing it, trying to get the report to the person who is going to make a decision on it, redoing the things we can't get our hands on because the referring physician has them and another hospital did the tests and that information never seems to make it in with the patient. We spend a lot of time reviewing the care we give to see if the quality is good. We spend a lot of time getting from "symptom" to "best diagnosis," and that route—because medicine is not a precise science, it is more of an art—is often circuitous compared to the direct route. All of those things would be enormously helped by good information systems. So I can't emphasize enough how critical improved information is to delivery of quality care.

[The prepared statement of Dr. Garthwaite appears on page 104.]

Chairman ROCKEFELLER. Do you know that the budget for research has been cut again for this year?

John, would you agree with that—there are certain cuts, and different cuts mean things to different people, but would you agree with what he said about that?

Mr. BOLLINGER. As I understand it, the research line has been cut by something like $40 or $50 million again this year. Again, I hate to overuse the word devastating, but research is such a fragile account, and when you tinker with it, that house of cards comes tumbling down. PVA has for years strongly advocated for a level of funding in research that will enable VA to attract young scientists to do the work that needs to be done. Ultimately, research translates into hands-on patient care; we see it that way. I would agree that Congress needs to take corrective action to ensure that the research line item is up again to where we believe it should be.

Chairman ROCKEFELLER. That's a good point.

It is going to be very interesting these next few years or 10, I'm not sure what it is. This whole question of establishing fiscal responsibility within the Congress, if you do the right thing federally with your budget and your 30-year interest rates are below 6.5 percent, that basically means that, let's say, a veteran or a physician who is buying a home may be paying $1,700 less per year for that home than they otherwise would have been because of fiscal restraint. But that then means in the meantime that budgets are getting cut. It is a very difficult thing.

You have got a new President coming in talking about health care reform, welfare reform, investing in the things that are really important, making cuts. He cut out 115 programs the other day, some of which I am sure affect West Virginia, but I suspect I am going to support him on it because I feel if you are going to get rid of things which are of less priority to save things which are of more priority,

then you can't have everybody applauding everything, and so you might as well just accept that.

It is very interesting about the proposed research cuts because that is what business did too, back in the harder times. They cut their research budgets just as the Japanese were not cutting theirs, and the Japanese would not cut them, knowing that if they got ahead in research, then when they came out of the recession they would be that much farther ahead, and we didn't understand that. Now all of a sudden, talk about FTE cuts—GE was having FTE cuts, as were General Motors and other major companies, of tens of thousands of people. And they come out healthier; they come out healthier. It is really interesting intellectually, that they got rid of so many people, and I don't know if they bought hundreds and hundreds of thousands of computers to make up for all of that, or whether they were just grossly overstaffed in the manner that very large organizations can get to be.

But there is tension, John, isn't there, because I think the President means it on reducing the Federal budget deficit. I think he is right in meaning it. And then having said that, you then come to the point where there are the effects of that and then how do you try to make those decisions as wisely as possible? What you know is that in the aggregate you are going to have to end up cutting somewhere because that is the only way you reduce it. It is either cutting out or reducing in size or whatever, but you have to do that. There is just no way around that. Then everybody sees what they want as being the most important. And there are some things that are more important than other things, there just are, and that's not whether you are in this committee or that committee, it is just that some things are more important. So, that process is troublesome, isn't it?

So, what you're saying in a sense is, while we are going through this, we ought to be acting intelligently in the way we do our business.

Dr. GARTHWAITE. Absolutely. There are tremendous opportunities to save money and do things better in health care. I really think information systems ultimately will be a large key to how we do it better. I have a clinic every Friday where I see about 15 to 20 veterans, mostly with diabetes. The charts are this thick. The most significant improvement in the last 10 years in that clinic has been a computer system that prints out all their prescriptions. When I renew prescriptions, you know every diabetic has a lot of them—syringes, alcohol pads, testing sticks, two types of insulin, some other medications—I used to have to write every one of those because prescriptions expire. So I had to write every one, sign every one, get it correct. Also, doctors don't always remember what they take. Now, I not only can do that very quickly, but I can also check to see if they get their refills at regular times. If somebody says they take every pill and we've only given them 60 for the last year, you have to wonder if they have another source or they are not taking their pills. I have actually made a couple of diagnoses that have prevented hospitalizations by sending out a home health nurse and instructing the family, so that they make sure that they get their medications.

So, I think it is just doing it better. But we're left with a paper record that is an outgrowth of an era many, many years ago, when there weren't many tests to be done and there weren't multiple consultations to be had. I think we have a great opportunity. I think VA's computer system, and many of the residents who rotate through different hospitals will affirm this, is an outstanding computer system.

Chairman ROCKEFELLER. I am going to submit some questions to each of you. But all of a sudden, after I don't know how many years, I read that there is something like a 40-percent increase in the number of young people applying to medical school. Can you explain that?

Dr. GARTHWAITE. I don't know. I know we've seen it locally, but I don't know exactly the reason.

Chairman ROCKEFELLER. Could it be something to do with the fact that health care is getting so much attention that people just make the assumption that this is going to be interesting, fast moving, nationally focused?

Dr. GARTHWAITE. If I remember right, I think there is some evidence that people are interested in helping other people; there is some bit of a pendulum swing to more altruism.

Chairman ROCKEFELLER. Yes, I think you are right about that.

Dr. GARTHWAITE. I think some polls would suggest that. Someone seated behind me suggests that more women are going into medicine. It is a good career opportunity for women. I think enrollments in most medical schools in terms of proportion of men and women have dramatically improved. I think 40-some percent of our class is women. So I think it is a very positive statement and a good career opportunity.

Chairman ROCKEFELLER. John, any thoughts on any of this, any final words?

Mr. BOLLINGER. You mentioned that there do have to be cuts. I think we recognize that. I think it is important, though, as we go through that process, that we ensure that, in the case of VA, what VA does well they continue to do. I think there is a danger that we can get so wrapped up in making sure that this appropriation is cut and that appropriation is cut, pretty soon we've jeopardized the system to the degree that it might not be repairable.

I think it is just very important that we don't go the way of Canada and the Canadian veterans' system; that we ensure that VA plans ahead, that they look to the future and they say here is a hospital that we need to preserve, here is another hospital that we need to preserve; that they make sure that those hospitals are run well, they provide quality health care, they support the special services that VA does well, again, like SCI care, blind rehab, and those kinds of things. VA is a natural resource, and it would be a tragedy if we were left without it.

Chairman ROCKEFELLER. And that is not going to happen, John, not on my watch or anybody else's. It is just not going to happen. There will be things that make us worry, that make us nervous, but I just dismiss the Canadian experience out of hand. We are going to make sure that the VA system works the way it ought to work. In

fact, as I have been saying for the last 4 or 5 months, it has a chance to work a whole lot better than it has been working, because we now put it in competition for a group of 25 million veterans who have not been able to get to it before, and then give it a jump start in resources to help in that process. None of this discounts anything of what you've said. It is just a time to worry in general because we're doing this. I hope and pray that we will do it right. If we had more people like the two of you, I know we would.

Thank you both very much.

[Whereupon, at 4:36 p.m., the Committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN JOHN D. ROCKEFELLER IV

While many of us in Congress struggle against forces aimed at killing all chances for national health care reform, several States have shown us that reform can happen when the needs of constituents outweigh the misleading commercials of special interest groups.

Universal coverage and employer mandates may be debatable issues in Washington, DC, but they are essential ingredients in health care reform in Washington State. Health alliances may seem frightening to some, but the people of Minnesota, Florida, and Washington State have already decided that they are the best way to provide cost-effective medical coverage for their citizens.

I applaud the efforts of the many States that are moving full steam ahead with plans for health care reform. These State plans provide the perfect opportunity for us to learn from their successes and to learn from any problems that they encounter.

In addition to illustrating how various reforms work in the real world, State reform programs will show us how reforms affect existing Federal medical programs, including the VA medical system. Unfortunately, current Federal law makes it impossible for VA facilities to participate fully in statewide health care reform efforts. A variety of restrictions, enacted for good and noble reasons, will prevent VA facilities from competing as providers in those States. We will hear examples of those restrictions at today's hearing.

As Chairman of the Senate Committee on Veterans' Affairs, I want to make sure that all our veterans get the best possible care, in those States and across the country.

I strongly believe that Congress must act quickly to enable VA facilities to participate in some of these State health care reform efforts, in order to strengthen the VA health care system in those States and to enable us to learn what kinds of changes are needed in the VA medical system as a whole. Of course, all States will be able to participate in State or national health care reform activities when Congress passes a national bill that revises the laws governing the VA health care system.

At today's hearing, we will hear from some of the VA officials and advocates who have a vision of how medical services for veterans can be improved through health care reform efforts, and how a pilot study in several States can make sure that happens.

We will focus on five of the States that are moving most quickly to implement health care reform: Florida, Minnesota, Tennessee, Vermont, and Washington State. We will learn what is needed to enable the VA medical centers in those States to participate in health care reform, and what Congress needs to do to make that happen.

PREPARED STATEMENT OF SENATOR BOB GRAHAM

Mr. Chairman, thank you for holding today's hearing in such a timely manner. Health care reform is on the minds of all of our citizens, and our veterans are no less anxious to find out what kind of health care they will receive under health care reform.

I would like to take a moment to comment on the work that the State of Florida has done to prepare for health care reform. Florida has taken the lead on this issue by enacting legislation to voluntarily sign up all small businesses into their Community Health Purchasing Alliance. The second phase of Florida's health reform plan will be introduced shortly and will phase in coverage for the Medicaid and uninsured populations, approximately 2 million people. Florida's goal is to provide full access to coverage by December 31, 1994.

Although VA is not included in Florida's Health Care Reform Acts of 1992 and 1993, the Florida Department of Veterans Affairs is also ahead of the pack in planning for health care reform. Florida is represented today by Malcom Randall of the Gainesville VAMC. I have known Mr. Randall for many years and am once again impressed with his insight and ideas on this issue. Mr. Randall has taken early action to consider how VA will fit into health care reform and has organized a strategic planning committee that includes representatives from the Florida VA, veterans service organizations, and veterans medical facilities officials. I commend him on his efforts to address the critical health care issues facing Florida's veterans.

The Committee has suggested the possibility of a states pilot program. I believe that Florida would be an ideal state to participate in such a program. If I am correct, I think that Florida, with the help of Mr. Randall, has already developed, or is in the process of developing, a plan for VA participation in health care reform and could move into a pilot phase immediately. I hope that the Committee will recognize their fine efforts should the pilot program go forward.

PREPARED STATEMENT OF SENATOR BEN NIGHTHORSE CAMPBELL

As Congress and this committee consider national health care reform this year, we must look to those States that have already begun the process of reform. In particular, we must look at the way veterans, and the VA system, are affected by State reform plans.

In my own State of Colorado, a study called ColoradoCare was commissioned to examine and put together a universal health care plan. The initial readings of this study, which now sits on a shelf somewhere in the state capitol, indicate it does not mention VA's role in a state health care reform

program. Now it looks like Colorado will wait for the Federal government to lay the ground rules for reform.

About six states, however, have initiated comprehensive health care reform. I applaud their efforts, and I hope we can all learn from them.

One of the first lessons we have learned from these state reform plans is that under current law, VA cannot participate fully in these health care plans because of certain restrictions on access and emphasis, such as limits on outpatient care. For obvious reasons, VA must be able to participate in these plans.

Otherwise, VA usage may decline before the Federal government hits the pavement with real reform. If the VA system loses folks before reform happens, it will be difficult to bring them back into the system.

Paralyzed Veterans of America (PVA) has recommended that within those States embarking upon health care reform, VA facilities should be given flexibility to offer comparable benefits and relief from regulation necessary to become an equal partner within the State system.

I believe this recommendation deserves serious consideration, and I appreciate the work that PVA and Chairman Rockefeller have done in this regard.

Thank you.

PREPARED STATEMENT OF SENATOR STROM THURMOND

It is a pleasure to receive testimony concerning the Department of Veterans Affairs health care system and its role in State health care reform programs. I commend you, Mr. Chairman, and the distinguished ranking minority member, Senator Murkowski, for scheduling a hearing on this important issue. I extend a welcome to our distinguished witnesses—Directors of VA Medical Centers, officials from the Department of Veterans Affairs, and representatives from the Paralyzed Veterans of America. This committee appreciates your dedication to all veterans and we value the contribution of your knowledge and expertise.

Mr. Chairman, while the National government continues the debate on comprehensive health care reform, many states are taking action. It is a great strength of our federal system that allows the States to experiment with approaches to complex public policy issues. Hopefully, the work which is achieved in the individual States will result in a better solution for the Nation.

While we attempt to address the problems of our health care system, we need to preserve the successful elements of our Nation's health care structure. Furthermore, as the debate on national health care reform proceeds, proper consideration must be given to the unique needs of veterans. For many years now, the Department of Veterans Affairs has been ably providing for the needs of the veterans of this country. It is essential that the VA health care system remain an independent system, provided with the resources to furnish quality care to our veterans.

As various State health care plans are established, some adjustments to the VA medical system may be necessary. I look forward to the testimony of these

witnesses which will help this committee determine what changes might be necessary.

Mr. Chairman, I look forward to working with you, members of the Committee, the Department of Veterans Affairs, and other members of the Administration to ensure that our veterans receive the health care they need and deserve.

PREPARED STATEMENT OF SENATOR JAMES M. JEFFORDS

It is a pleasure to have here today representatives from five states that are leading in State health care reform, including my own State of Vermont. I am especially pleased to welcome Dr. Howard Green here today from Vermont's White River Junction VA Medical Center.

This is a very important hearing for the Senate Committee on Veterans' Affairs as we continue to further discuss health care reform. VA must continue to play a prominent role in our Nation's health care system, and therefore, must be able to work within new State health care reform initiatives. As our Nation's largest health care provider, VA offers expertise in a wide range of health care areas and research.

President Clinton has laid out his plans for VA participation in his health care reform package. I support his reform initiative, but I want to be sure VA will be able to fairly compete with private health care options. VA eligibility reform must coincide with health care reform if VA is to compete.

This committee will propose legislation that will take advantage of progressive State initiatives. Several pilot programs will be set up to determine how VA can best furnish health care services in States with reformed health care system, and under any national health care reform plan that may be enacted.

All of these states' health care reform efforts offer an opportunity for VA to capitalize on its future role in national health care. Vermont's reform efforts are on the verge of implementation and will allow the VA to experiment with changes hand-in-hand with reform.

This is a critical and exciting time for VA. For the first time, all veterans could be eligible to receive care at a VAMC, regardless of their service connection. However, VA needs to be prepared to make the proper changes that will let it remain a contender in the health care arena when national health care reform is implemented. I believe VA pilot programs in this regard are extremely important and serve as crucial insight into the future capabilities and services the VA will offer.

It is extremely important that we consider not only setting up pilot programs in States that have already implemented health care reform, but also in States, like Vermont, which are in the process of reforming. VA must be prepared to play a role during the process of implementation.

I look forward to hearing more about these States' health care reform plans and the initiatives VA is planning to take in order to work within new State reform efforts.

PREPARED STATEMENT OF ROBERT PETZEL, M.D., CHIEF OF STAFF, VA MEDICAL CENTER, MINNEAPOLIS, MN

In 1992 the Minnesota Legislature passed health reform legislation (MinnesotaCare) based on the principles of managed competition, mandated universal coverage and a global expenditure ceiling. In addition, the law provides for medical education and research reform in the state. Minnesotans will be required to pick a health care plan choosing between a Regulated All Payer Option (RAPO) or an Integrated Service Network (ISN) . All providers will be affected under the state reform efforts.

These laws reform the state medical delivery system by: 1) Mandating universal health care coverage for all Minnesotans, 2) Encouraging health care providers to collaborate by joining together to form (ISN's), 3) Requiring ISN's to provide a uniform basic benefit package to all Minnesotans, 4) Encouraging employers to join with one another to form health care purchasing cooperatives, and 5) Limiting the reimbursement of non-ISN providers through a State "all payor" reimbursement system. These laws create a state-funded health insurance plan for uninsured citizens who are not eligible for Medicaid or other forms of State or federal health care and reform private insurance practices to reduce barriers to obtaining private health insurance (e.g., restricting preexisting condition clauses).

These laws further require health care providers and systems to reduce the rate of health care inflation by conforming to global expenditure ceilings set by the State; and require participation in State-wide data collection efforts designed to ultimately control costs through the development of State practice parameters, and quality assurance and health care outcome measurements.

Some of the characteristics of the ISN's include 1) facilitating the enrollment of those with severe medical conditions and special needs through risk adjustment and reinsurance mechanisms, 2) providing primary care within the lesser of 30 minutes travel time or 30 road miles, 3) providing primary care within 10 miles of any city with a population greater than 2,500, 4) providing inpatient hospital care within 60 minutes travel time, 5) maintaining a net worth of greater than $1,000,000, and 6) requiring the ISN's to accept eligible enrollees who reside anywhere in the service area. Already MinnesotaCare is covering a segment of the population (90,000 people) . This year those Minnesotans who do not have employer or government assistance will be eligible. In the short term, veterans will have several options once MinnesotaCare becomes available to them. The MinnesotaCare plan is extremely complex and requires very detailed planning. The Minneapolis VA is planning its strategies now, since MinnesotaCare is already legislated. These strategies for the Minneapolis VA include:

1) Implementing VA Minnesota Primary Care System—If we are able to implement this system, it would provide accessible primary care sites to veterans. Secondary and tertiary services would continue to be provided by the VA Medical Center. Major systems in our infrastructure would need overhauling for primary care system implementation. Data systems, including medical records, would need to have appropriate computer technology to collect and transmit quality and workload data for the Minnesota Health Care Report Card. A consultant would be hired to perform an actuarial, market research survey, market plan, implementation plan and a business plan to effectively position the primary care system.

2) Managed Care Institute—Minneapolis VA is presently exploring the possibility of leasing property to a non-VA entity which would construct an outpatient clinic or other facility to serve its members under VA's "Enhanced Use Program." VA would also gain access to the facility. The VAMC and the health care provider will enter into a joint partnership to develop an institute dedicated to the study of managed care. The partnership would also enable the VAMC to expand health care services for veterans at no additional cost to the government.

3) Establishing internal strategies—Minneapolis VA is enhancing its ambulatory care area so as to be able to provide easy access and customer driven services. Processes established to enhance customer services and access include: improving concurrent review, preadmission screening, and discharge process; and reducing waiting times.

4) Securing the role of education and research—The Minneapolis VA is a member of the advisory committee of the Commissioner of Health that is drafting legislation to reform funding of medical education and research. This will ensure that VA will continue to be a major provider and participant in policy development for medical education and research.

5) Meetings have been held with the Commissioner of Health, Minnesota Health Care Commission executives, key state legislators and community health care leaders. The state is actively interested in maintaining the $200 million plus that VA provides Minnesota for needed services.

All of these enormous efforts will make it possible for VA to compete in MinnesotaCare. We now need changes in Federal law to enable VA to compete in Minnesota Health Care Reform.

PREPARED STATEMENT OF JOSEPH M. MANLEY, DIRECTOR, VA MEDICAL CENTER, SEATTLE, WA

Washington State enacted one of the most comprehensive health care reform bills adopted by any state with the passage of the Washington Health Services Act of 1993. Several aspects of the Washington State reform plan are similar to what has been proposed by President Clinton for national health care reform. In summary, the Washington State law:

- Provides for universal coverage
- Is a managed competition plan with premium and payment caps
- Creates a Uniform Benefit Package (UBP) of services
- Requires employers to offer at least 3 Certified Health Plans
- Has phased implementation beginning 7/1/95 until universal coverage is achieved on 7/1/99
- Requires all health plans to be managed care organizations
- Provides subsidies for low income enrollees
- Envisions enrollee point-of-service cost sharing
- Provides skilled nursing facility, home health, and hospice services

By January 1995, the exact contents of the Uniform Benefits Package (UBP) will be determined by a State Health Services Commission (HSC). The Commission will also set a maximum premium that can be charged for the UBP. Every state resident, including all veterans, will be required to obtain at least the UBP by 7/1/99.

Employers will be required to pay at least 50% of the lowest priced UBP premium offered for their full time workers, but may pay up to 100%. Employers will pay a pro-rated percentage of the costs of coverage for their part time workers. Large businesses (7000+ employees) will be able to offer their own plans to their employees.

Washington is one of the few states experiencing a growing military presence and an increasing veteran population. Veterans and their dependents now total almost 1.9 million residents, comprising nearly forty percent of the state's population. Washington State has a broad range of community types and sizes, a diverse economy, varying topography, and a VA facility in each of its four geographic quarters. These medical centers have longstanding, close relationships among themselves and with community leaders. The VA's health care expenditures in Washington totaled nearly $270 million in fiscal year 1993.

VA medical centers treated 51,571 unique Washington State veterans in fiscal year 1993 (7.98% of the 646,050 veterans in the State). Information by Primary Service Area (PSA) is summarized below:

PSA	Vet Pop	%State Pop	Pts Treated	%Pop Served
American Lake	135,656	21.00%	14,881	10.97%
Portland	50,306	7.79%	3,681	7.32%
Seattle	338,884	52.45%	20,846	6.15%
Spokane	75,389	11.67%	7,960	9.75%
Walla Walla	45,815	7.09%	4,811	10.50%
State Total	646,050	100.00%	51,571	7.98%

Over the past six months, representatives from each of the four VA medical centers have met regularly to assess the impact of the State reform law, and to begin determining organizational needs and preparing business plans.

If VA is eventually permitted to participate in the State Plan, we envision a state-wide, VA structure to provide enrollee tracking, marketing, insurance, contracting, and liaison with Washington State entities. This organizational structure could also be a conduit for the flow of funds. Under this organization, the existing VA facilities would serve as separate operating divisions for their respective primary service areas. In accordance with State law, premium rates would likely vary among the stations geographic areas to reflect different competitive pressures and the costs of doing business.

Potential local and state-wide partnerships with other providers are currently being explored. These include Madigan Army Medical Center and other

Department of Defense facilities, Indian Health Service facilities, the University of Washington Medical Center, Sisters of Providence health care system, and others. Our goal would be to offer accessible, cost-effective, high quality health care to enrollees throughout the state to the extent that we are permitted by law.

We believe a number of major issues will need to be addressed if VA is to be a viable provider under the State of Washington's health care reform. These include increased management flexibility. Operationally, VA will need to change its structure, practices, and procedures. Local management will have to develop expertise in business planning. Most importantly, our future focus must be on better meeting the needs and expectations of our "customers."

PREPARED STATEMENT OF HOWARD H. GREEN, M.D., CHIEF OF STAFF, DEPARTMENT OF VETERANS AFFAIRS MEDICAL AND REGIONAL OFFICE CENTER, WHITE RIVER JUNCTION, VT

Mr. Chairman, members of the Committee: I am Dr. Howard Green, Chief of Staff of the Veterans Affairs Medical and Regional Office Center at White River Junction, Vermont, a position I have held for 21 years. I am a veteran of the U.S. Navy and served from 1961-1963 in the Nuclear Submarine Force as a physician on the Gold crew of the *U.S.S. George Washington*, the first Polaris Missile submarine. I am a General Internist with a subspecialty in Nephrology. I received my education and training at Dartmouth and Harvard.

Before entering into this task, I would give special acknowledgment and thanks to Senator James Jeffords, a member of this Committee, for his interest and willingness to participate on our behalf with the Vermont State Legislature. Although not a member of this Committee, Senator Patrick Leahy, who sits on the VA, HUD, and Independent Agencies Subcommittee of the Appropriations Committee has maintained a strong supportive role on veterans' matters within the state and is supportive of a substantive role within state health reform for our Medical Center.

State Health Care Reform

The states are in various stages with regard to enacting health care reform legislation. Some have already done so, others are active in the legislative process and others appear to be taking a wait and see position. Regardless of this, the Department of Veterans Affairs should use this opportunity to structure a policy plan on how it is going to address the care of veterans in a rapidly changing environment. In a sense, clearly in some states, we are in a position where the horses are on the track and we have to figure out how to get into the race.

In other states, which are in the active process of passing health care reform legislation, it would make a great deal of sense for local officials to get into a dialogue with legislators about the needs of veterans so that the statutes would be felicitous to the plans and wishes of veterans and the Department.

The situation in Vermont serves as a case example. The Vermont House of Representatives is currently considering health care reform legislation. A special Ad Hoc Committee was formed by the Speaker to consider this topic. The legislature passed Act 160 in 1992 setting up a Health Care Authority

whose charge was to present two plans for health care reform to the legislature; one a single payor plan and the other a multi-payor plan. Our Medical Center has had a role in this process because our Chief of Medicine was appointed to the Health Care Policy Advisory Committee which advised the Health Care Authority. The Director, Chief of Medicine, Associate Chief of Staff for Ambulatory Care and I met with Governor Howard Dean on November 30, 1993 to discuss the Medical Center's role. Subsequently, there have been several meetings with members of the Health Care Authority. On January 24, 1994 the Director, Chief of Medicine and Ms. Patricia O'Neil, from the Office of the Assistant Secretary for Policy and Planning, testified before the Ad Hoc Legislative Committee of the Vermont State legislature. The Legislature is in the active process of drafting reform legislation. It is important to note that the Health Care Authority Report embraced the principles of universal access and a standard minimum benefit package.

We are having ongoing discussions with the Ad Hoc Legislative Committee as they attempt to craft a legislative package. Initially, the legislators were uninformed about the programs of VA. We are attempting, on a regular basis, to increase their level of understanding of the needs of veterans. The legislators have expressed genuine interest, as evidenced by the fact that the scheduled 20 minute hearing at which we testified was extended to an hour and 20 minutes.

We do not know exactly what form the Vermont legislation will take. The process is dynamic and lobbying efforts from competing interests are ferocious.

There appear to be some common principles which remain alive among the Vermont legislators and these are:

- Universal Access
- Some form of minimum benefit plan, and
- Emphasis on primary care access close to the citizen's place of residence

Additionally, there appears to be a strong sentiment for managed care through purchasing alliances.

Should the final legislation approximate in its substance, these principles, we see the impact on Veterans to be substantial.

We are a rural state. If VA were to participate in such a plan, the requirement of primary care access would have profound effects on our ability to meet our mandate to eligible veterans. The proposed requirement that all plans provide access to primary care within 30 minutes driving time from the place of residence has caused us to develop a plan. We have opened a fixed clinic in Burlington, Vermont. We are using our mobile van to service outlying communities in the far northern part of the state. We have identified sites where we will have to acquire primary care services if we are to meet the 30 minute mandate. Our initial plan would be to acquire these services where possible on contract. Secondary care would be provided at the Medical Center in White River Junction. Tertiary services would either be purchased at the Medical Center in Burlington, the Dartmouth Hitchcock Medical Center or provided by VA facilities in Boston.

We have begun the planning process to redirect our practice focus towards primary and preventative care, geriatric care, with emphasis on long-term and

intermediate care issues, and home care while maintaining our strong secondary level of acute care.

Our major concern is one of timing - unless we are prepared to respond to the State Reform Legislation, we see a large potential loss in the number of veterans who will use our care system.

Mr. Chairman, we will be involved in charting unknown territory. We will inevitably make mistakes. It is important that we have the latitude for honest errors. Our system of information and attendant oversight should be designed to reduce the magnitude of error. I know you and the Committee will understand this. I thank you for this opportunity to testify on this important issue. Your staunch support of the Veterans Health Care System and its role in the emerging Health Care Reform effort is greatly appreciated.

PREPARED STATEMENT OF MALCOM RANDALL, DIRECTOR, VA MEDICAL CENTER, GAINESVILLE, FL

Mr. Chairman, May I first express my appreciation, on behalf of the Directors and staff of the VA Medical centers in Florida, for the opportunity to appear before this distinguished committee which has contributed to the care of America's veterans.

Florida is one of only a few states that have enacted legislation to begin the health care reform process. The Florida Health Security Plan was developed to approach health care reform in a comprehensive manner—seeking to reform all aspects of health care financing, delivery, purchasing, and regulation concurrently. The Florida Health Care Reform Act was enacted in 1992 and the Florida Health Care and Insurance Reform Act in 1993.

In the fall of 1991, the Governor of Florida requested that Dr. Leighton Cluff, Gainesville VA Distinguished Physician, chair the "Florida Health Care Work Group." The purpose of the work group was to develop recommendations for the governor and the Florida legislature regarding the principles of health care reform. Since I felt this was an appropriate contribution that VA could make to health care reform at large, I immediately agreed that Dr. Cluff's experience in health care policy issues as a former President of the Robert Wood Johnson Foundation would uniquely qualify him for this role. In 1992, the Florida legislature passed the Health Care Reform Act of 1992–requiring the development of a health plan to ensure that all Floridians have access to high quality, affordable, basic, health care by December 31, 1994.

The Agency for Health Care Administration (AHCA) was created by that legislation and is responsible for overseeing the development and operations of the state health care plan. Florida's health plan utilizes a market-based approach, managed competition, to provide universal access, basic coverage and contain costs. Eleven Community Health Purchasing Alliances (CHPA's) were established throughout the state to band employers and employees together, collect premiums, and distribute those premiums to certified Accountable Health Plans (AHP's). The CHPA's must offer all AHP's that meet state-established criteria. Currently, an AHP must be designated by the Department of Insurance as either an HMO or an insurer. The AHP's will offer benefit packages that, at a minimum, include the state's defined basic benefits. Basic health care for all Floridians shall provide a continuum of care, early

diagnosis and treatment services and managed care from a primary care provider.

Request for proposals for AHP's are slated for issue in three phases: first for small employers, second for Medicaid recipients and families who are at 250 percent or less of the poverty level, and third for state employees. Participation in the Florida Health Plan is voluntary because of current Employee Retirement Income Security Act of 1974 (ERISA) restrictions.

In addition to Dr. Cluff's role, other VA officials have been actively involved in the Florida health care reform process. With the passage of state legislation, I began working with the Agency for Health Care Administration, in my role as VA's Florida Network Chairman, to define the role VA could play in a reformed health care market. I also regularly consulted with the District Counsel, and Kathy Jurado, the Assistant Secretary for Public and Intergovernmental Affairs, and I testified before both the Florida Senate and House Health Care Committees to discuss the contributions VA makes to the health care of Florida citizens.

We highlighted for state legislators and the AHCA staff that with over 1.7 million veterans residing in Florida, the VA health care program is a vital contributor in the state health care system. For example, the Florida VA facilities provide over 1.2 million outpatient visits annually and treat almost 50,000 inpatients each year. Over 46 percent of the VA hospital admissions are for veterans who are considered financially indigent and have no health insurance. In addition, Florida's veterans are older with over 38 percent being age 65 years or older. Generally, patients 65 years and older consume 3 to 4 times more health care resources than younger patients.

In my role as the Lead State Director for Florida, I initiated strategic planning efforts to aid in the transition into health care reform. The focus of the strategic planning process is on integrating the VA health care program with the Florida health care reform program. The Directors of the VA Medical Centers within the Florida Network set as their primary goal the development of health care delivery that will ensure that VA can successfully compete in the reformed health care market.

In January 1994, I appointed a Strategic Planning Committee to develop a strategic management plan detailing the processes that are key to the success of the program. The Florida Strategic Planning Committee is comprised of clinical and administrative staff representing each Florida VA medical center, representatives from the major veterans service organizations in Florida, the Executive Director of the Florida Department of Veterans Affairs, and the District Counsel. The Florida Strategic Planning Committee has begun meeting to insure that the veterans' organizations, the state Department of Veterans Affairs, and medical center staff are involved in the process from the beginning. A two day meeting of this committee was held on January 19 and 20.

As a first step in the planning process, we conducted a situational analysis. This process included a comprehensive examination of the Florida VA health care program's strengths, weaknesses, opportunities and threats. This analysis facilitated an evaluation of both the internal organization (strengths and weaknesses) and external forces impacting the organization (opportunities and threats). As a next step and using the results of the situational analysis,

objectives and action items were developed to prepare VA for the competitive health care market. The Florida veterans can expect, as a result of a competitive VA health care system, increased access, timely service, and an enhanced focus on primary care. With a focus on providing increased access to veterans, health care reform efforts will enable the VA facilities in Florida to provide ongoing primary care and comprehensive and timely specialty care to a larger portion of the Florida veteran population.

After extensive discussion and careful analysis, it is the consensus of the Director of the Florida VA medical centers that, collectively, VA in Florida is in a position to successfully compete in the new health care environment. As a network of medical centers and clinics, we can provide all aspects of health care to ensure a comprehensive continuum of care is available.

Those of us who are Directors in VA medical centers in Florida believe that health care reform will work. We can compete successfully. We can compete based on the quality of our staff. We can compete on overall hospital quality, as measured by the last rounds of Joint Commission on Accreditation of Health Care Organizations scores, where VA outscored private sector hospitals. We can compete on cost. We can compete on our experience in working with a global budget. We can compete because we feel the future is now, and we will compete to make health care reform work in order to insure the future viability of VA health care system.

PREPARED STATEMENT OF LARRY E. DETERS, DIRECTOR, VA MEDICAL CENTER, NASHVILLE, TN

Thank you for the opportunity to appear before you today to discuss state health care reform and its impact on veterans' health care in the state of Tennessee.

On January 1, 1994, the State of Tennessee implemented the TennCare Demonstration Project, a four year project to reform the state Medicaid Program and provide health care to medically indigent citizens of the State of Tennessee. Three groups of Tennesseans are included in the TennCare Project. The first and largest group (one million) are the state's Medicaid recipients. The second group are citizens of Tennessee, estimated at 700,000, who were uninsured in 1993 and were not eligible for Medicaid. The third group of approximately 4,000 are citizens who have been denied health insurance because of preexisting medical conditions. Many veterans (including many who have received a portion of their health care from the four Department of Veterans Affairs (VA) Medical Centers and two Outpatient Clinics in the State of Tennessee) are included in these three groups. TennCare may be attractive to these veterans because it offers a more comprehensive health care plan than VA is currently able to provide. TennCare provides its beneficiaries preventative health services, doctor's visits, hospital care, ambulatory surgery and prescriptions within 30 minutes of their home. It also provides these services for the spouse and any dependent children.

The TennCare project is a capitated, market driven managed care system. Managed care organizations (MCO) compete with one another to enroll patients in these three categories. On January 1, the one million Medicaid recipients were automatically assigned to one of the twelve managed care organizations in the state. During the month of January these individuals were permitted to

switch to the plan of their choice. The other two groups (medically indigent and uninsurable) must complete an enrollment form and elect a managed care organization. The state has capped the total number of non Medicaid enrollees at 300,000 for 1994. It is the state's hope that additional resources may be identified to allow the cap to rise until it covers the estimated 700,000 medically indigent citizens.

There are 521,000 veterans residing in the state of Tennessee. Last year the VA facilities collectively provided care to approximately 14% (74,000) of these veterans. It is too early to determine the impact of the TennCare Program on workload at VA facilities since most of the veterans at risk of leaving VA did not begin the enrollment process until January. Obviously the larger the number of medically indigent citizens of Tennessee who enroll, the greater the opportunity for our veteran patients to choose to leave the VA system.

The Department of Veterans Affairs facilities in Tennessee provide a high quality of medical care in well equipped and staffed hospitals and outpatient clinics. We have excellent relationships with veterans organizations, other health care providers and our patients. We believe that we can effectively compete with private sector providers and provide the state and federal government with leverage to reduce the rapidly rising costs of health care in this country. The President's Health Security Act clearly envisions the Department of Veterans Affairs as a major provider for veterans and their families and outlines the necessary legislative and regulatory changes needed to allow this to happen. Since Tennessee is moving in advance of national health care reform, we are at a disadvantage in this competitive market. Many of our patients are being enrolled with other managed care organizations, many physicians and group practices in more rural areas of the state are contracting with these MCO's and they are gaining experience and expertise in how to function in this new environment. As more states enact their own reform legislation, the Department of Veterans Affairs health care system could be further disadvantaged.

Thank you again for this opportunity.

PREPARED STATEMENT OF ELWOOD HEADLEY, M.D., ACTING DEPUTY UNDER SECRETARY FOR HEALTH, AND DIRECTOR, VA NATIONAL HEALTH CARE REFORM OFFICE

Good Afternoon. It is a pleasure to be here today and have this opportunity to speak to you briefly about the Department of Veterans Affairs and state health care reform.

When the President submitted the Health Security Act to Congress on September 22, 1993, the country had the promise of a future that would guarantee all Americans access to affordable health care. It also gave VA the opportunity to enter into a new era in delivering health care services for veterans. The Health Security Act retains VA as an independent health care system and gives all 27 million veterans and their families a chance to enroll in a VA health care plan. That fact, coupled with the benefits of improved access, security, simplicity and quality that all Americans will enjoy under the President's proposal, are convincing arguments for the public's support, and in particular, the veterans' support of the Health Security Act.

In October 1993, in response to the proposed Health Security Act and the anticipated changes in VA health care delivery, the Secretary of Veterans Affairs established a National Health Care Reform Office to plan, develop and implement a coordinated and comprehensive approach to VA's successful participation in National health care reform.

Mr. Chairman, I know that you and the Congress are focused on national reform. However, many States are not waiting for enactment of national reform. They are actively pursuing state reform measures now. Therefore, one of the first activities of the VA Health Care Reform Office was an initiative to ensure and enable VA participation in State health care reform activities. We in VA plan to move with the States as partners in developing better ways to meet veterans' health care needs, reduce costs and maintain the highest levels of quality.

The VA has compiled extensive data on state-based health care reform activities occurring throughout the country. We have reviewed State legislative proposals, State health care commission reports and other materials to assess the extent to which we can anticipate some degree of effect on veterans' health care delivery. As a result of our review, we are focusing on nine (9) States and the Commonwealth of Puerto Rico that have already enacted State health care reform legislation or have received or requested waivers permitting Medicaid demonstration projects. The States are: Arizona, Florida, Hawaii, Maryland, Minnesota, Oregon, Rhode Island, Tennessee and Washington. In addition, we are closely monitoring States in which we expect significant health care reform legislation to be enacted in 1994. These include California, Colorado, Montana, New York, and Vermont, as well as the Commonwealth of Pennsylvania. We also recognize that nearly twenty (20) States have special commissions or task forces preparing reports to present to their legislatures, so we can foresee an increase in the number of States with health care reform plans in the coming months. We continue to monitor these reports and the activities of the legislatures.

With respect to the State legislation that has already been enacted, our review indicates that generally the States are first working to provide poor and uninsured citizens with health care coverage through managed care plans. They may also plan to phase-in additional categories of residents over a period of years. States, such as Washington, that have adopted universal coverage still require Federal waivers from ERISA (Employee Retirement Income Security Act), Medicare and Medicaid restrictions before they may achieve full implementation.

Now, let me address some specific concerns about VA and State health care reform:

While it is still too early to fully determine the actual effect on VA of state-based health care reforms, we do know that some veterans who currently use the VA system will gain increased access to other non-VA health care services. These veterans may elect to enroll in State-approved health care plans, rather than seek care from VA. This may be particularly true in States like Tennessee where the basic benefits package is richer than what VA is now statutorily permitted to provide, especially with regard to outpatient and preventive care services.

The number of veterans who will become eligible for State health care coverage under States reform varies. For instance, Oregon's reform sets the threshold at all citizens below the federal poverty level. Of the over 38,000 veterans treated at VA facilities in Oregon, approximately 4,500—or 12% of the patients—would meet this requirement. The State of Florida sets 250% of the federal poverty level as the income threshold for their "MedAccess" program. This could affect an estimated 21,000 of the 153,000 veterans treated by VA facilities in Florida—or a potential 14% of VA patients.

There are several challenges posed to VA with State health care reform:

We are a public health care system and lack experience in participating in a competitive environment. We do not currently have all of the necessary systems and structures in place to operate like a business. While we have gained some experience in recent years such as billing third-party payers through the Medical Care Cost Recovery (MCCR) program, we still have a long way to go in this arena.

We are a Federal health care system and lack experience in dealing with State governments. Most of the State health care reform legislation that has passed to date has not considered VA as a participant, primarily because the States are not aware of the significant role that VA plays in community health care. Although we have for years enjoyed effective working relationships with the State Directors of Veterans Affairs, we have generally not had a great deal of interaction with other State officials. We know that this must change and are working toward that end as you will hear later.

We are a national health care system and as such, have requirements including eligibility criteria that apply system-wide. Therefore, we currently lack the flexibility to tailor services to meet the diverse requirements imposed by each individual State's legislation.

We are an advocate for veterans and must strike a balance between maintaining VA's role as a provider under State health care reforms, and also ensuring that veterans have access to all the health care choices and benefits afforded the citizens of a State. In the words of Edward Albee, this is "a delicate balance," but one we view as our mandate.

VA has responded to the challenges of State health care reform in several ways.

First, the Department has developed a unified vision for VA's role in national health care reform. We have a system-wide commitment to participation in State health care reform as a key first step to meeting our vision.

Second, we designated one or more VA medical center Directors within each State as "Lead Director". These individuals are responsible for coordinating the State's plans for VA participation in State health care reform with an eye toward National health care reform. The Lead Director is expected to ensure that State and private sector officials are aware of VA's current role in the State and our interest in participating as plans are being made for State reform. Further, we are encouraging our managers throughout the country to become more involved in their States' health care reform activities.

Third, we have begun a state-based strategic planning initiative that brings together VA facilities in a State to develop a unified plan for providing health care services to veteran customers and identify actions required at the local and

national levels to ensure VA participation. We started this strategic planning activity with the VA facilities in six States that have implemented (or are implementing) significant state-based health care reforms. These States are Washington, Oregon, Tennessee, Florida, Vermont and Minnesota. However, this effort will be expanded shortly to incorporate facilities in the priority States.

Fourth, we have initiated a relationship with the Health Care Finance Administration (HCFA) to ensure appropriate consideration of VA and veterans in their review and approval processes of State requests for Medicaid waivers.

Fifth, we educate State officials on the role of VA in their communities. VA is an important national health care resource that enhances the health care capabilities of the State and also contributes significantly to the economic vitality of local communities. Last year VA spent $5.2 billion on goods and services for its medical centers while a labor force of 237,000 individuals substantially affected local economies. In addition, VA contributed $85 million to construction and acquisition of State veteran homes, and provided clinical training to over 100,000 students in the health professions.

Sixth, we provide information to State legislatures in a variety of forums to ensure that VA is considered in State health care reform deliberations. We also attend meetings with Governors' Veterans Advisory Committees and work closely with representatives of Veterans' Service Organizations at the State level.

Seventh, we will soon be providing the Congress with a draft bill—to authorize pilot programs in a small number of States to allow VA to fully participate in health care reform efforts in those states. As you know, when Congress enacted the laws which shape our VA system, it never contemplated the changes in the health-care environment we are now facing. Existing Federal law limits our ability to make the changes needed for participation in the competitive health care delivery environments emerging in some States.

Under the proposed pilots, participating facilities would be given authorities similar to those which are contemplated for the entire VA health care system under the President's proposal. The pilots would serve a dual purpose. They would enable us to actively participate in reformed State systems where our facilities might otherwise face a declining workload which might impair our ability to meet our mission, or result in deterioration in the quality of our services. More importantly, these pilots will help us learn how to best serve veterans in the competitive environment envisioned by the President's proposed Health Security Act.

Our proposed legislation would permit VA facilities in a State which has enacted health care reform to provide that State's veterans, and their dependents, with services on the same, or similar, basis as that veteran could receive from any non-VA health plan. Thus, at pilot sites, VA would be able to enroll veterans in a VA health plan just like any other competing provider in that State. If the State law required health plans to furnish enrollees and their families with a statutorily established minimum benefits package, the pilot VA plan would offer the same package. If the State program allows plans to sell services in addition to a basic package, the VA plan would also be permitted to do so.

I want to assure you that VA will continue to maintain the Nation's long-standing commitment to provide veterans with the care which they are now authorized to receive. Accordingly, our bill would exempt many veterans, notably service-connected and low income veterans, from States' requirement that they pay a premium, copayment or deductible. In that regard, the bill will be consistent with the President's proposal.

Other key provisions in our proposed bill would broaden the ability of pilot plans to both contract for the care of veterans and their dependents, and share resources with other health care providers when such collaborative arrangements are necessary and cost effective. The bill will authorize mechanisms for managing funds in pilot programs, and will authorize exemptions at pilot sites from certain constraints which limit administrative flexibility. Finally, the bill will include requirements that we report to the Congress on our experiences with the pilot programs.

In conclusion, Mr. Chairman, let me say that the Department of Veterans Affairs has set forth its vision to become a successful participant in the reformed National health care delivery system that this country will soon enjoy. We will offer a full range of services, enhanced by education and research, benefiting veterans and their families, and the Nation as a whole. Successful participation in State health care reform will further our goals. National health care reform represents an unprecedented opportunity for the VA health care system to become a key player in State and regional health care systems. We know that we must move ahead now with the States as partners and we want to ensure that VA has an effective role in the health care activities that are quickly moving forward in the States.

I thank you for this opportunity to speak with you and look forward to your questions.

PREPARED STATEMENT OF JOHN BOLLINGER, DEPUTY EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman and members of the Committee, Paralyzed Veterans of America (PVA) appreciates this opportunity to express our views on the challenges facing certain VA medical facilities in maintaining the quality and quantity of health care services for veterans in states that are about to impose major health care reform initiatives.

National health care reform legislation, currently pending in the Congress, will have a profound effect on the structure and the provision of services within the national VA system. To a certain degree, the tools that VA needs to help ease that transition are contained in the reform plan itself. In the meantime, several states have decided to move ahead of the federal government to implement their own unique reform plans. These state governments have completely ignored the contribution VA makes to health care in their state. They have also ignored the fact that VA should be a full partner in the provision of health care under those reforms. Likewise, up until recently, VA has been slow to realize the peril VA facilities in those states would find themselves in trying to compete over patients and cost with other private and public health systems while still restrained by current outdated eligibility criteria and restrictive administrative regulations unique to the federal government.

Five years ago, PVA realized that the states, frustrated by the lack of movement on the part of the federal government, would address the growing national health care crisis unilaterally by moving ahead with their own reforms. We realized that VA medical facilities could be in imminent danger if reforms in the state either enticed veterans out of VA into state programs to receive enhanced benefits, or precluded veterans from the state system on the assumption (most often false) that all veterans could receive all the care they needed through VA. On the one hand the VA patient base would be decimated and facilities would be closed, as was the case with the Canadian veteran health care system after Canada implemented universal coverage. Under the other scenario, VA health care facilities could be swamped with veteran patients without the resources to care for them properly. And, those veterans would continue to be blocked from the full continuum of care due to existing fragmented VA eligibility criteria.

This misunderstanding on the part of the states arises as much from their desire to reduce the cost of reforms by automatically excluding veterans from state programs in the same fashion as they exclude other federal beneficiaries-Medicare and DOD, for instance. It also comes from the false perception that all veterans are eligible for care through VA, and once they arrive on the VA doorstep all veterans can receive all the care they need. The PVA response to this issue was to heighten awareness within the states of the nature and importance of the VA health system, to correct misunderstandings over VA eligibility, and to point out the importance of VA being an equal, interactive partner in the development and implementation of state reforms.

PVA established its State Health Care Reform Project to monitor state reform activity. Through the work of the Project, PVA has raised the concern of potential conflicts with veteran health care through direct negotiations with the Commonwealth of Massachusetts during the late 1980's in the context of their now-stalled health care reform effort. PVA has also helped to resolve veteran eligibility conflicts in the reform efforts of both Hawaii and Tennessee. At the present time the project continually collects and updates health care reform data on all 50 states, the District of Columbia and the territories. The objective is to identify and help resolve conflicts between VA and the state before they happen. This is more important than trying to create appropriate interfaces after reforms are in place.

In January 1994, PVA published the first edition of its summary and status of state health care reform initiatives. This matrix indicates whether a state has included, or even made reference to, the VA health care system in its planning and legislative efforts. A copy of this document has been made available to every member of the Committee. Sadly, within this review of the reform literature, only two states have even mentioned that VA is a provider within their borders or a potential participant in their reform efforts. These omissions need to be corrected.

Over the past year PVA has communicated its concerns through a media campaign in state legislative periodicals, with the governors and top health reform planners in all 50 states, the members of appropriate Congressional committees, delegations and staff, and senior VA leadership (As an example we are attaching a letter dated November 12, 1993 which was sent to Secretary Jesse Brown). Our purpose is to create an awareness of how the state benefits from the contribution VA makes.

- VA provides care to a large number of medically indigent veterans relieving the state of extensive additional Medicaid costs, uncompensated care and public health care costs.
- VA provides a training resource for health manpower and a medical research base within the state
- VA, through sharing agreements and affiliations with health professions schools, is an integral part of the state's health infrastructure.
- VA is a large employer in every state.

From our review of state reform activity there are six states that have either enacted partial reforms or are in the process of imminent major reform implementation: Florida, Minnesota, Oregon, Tennessee, Vermont and Washington. Of these, Florida, Minnesota, Washington and Vermont will offer the most comprehensive reform and the most direct challenge to the VA system in their state. A summary of each state reform plan is attached to this testimony. In each instance, reforms enacted by these states, both large and small, already have, or most probably will, go into effect prior to implementation of national health care reform. VA must have the tools to interact and compete successfully with these proposals if it is to survive and maintain its existing comprehensive mission.

The Congress and the Administration must agree to give VA facilities in those states the flexibility to offer comparable benefits and the relief from regulation necessary to become an equal partner within the state system. This flexibility must be provided in the form of pilot programs involving VA facilities in those states listed above. The pilot programs will give VA in those states the opportunity to become a full participant in the health care system. It will also provide valuable experience to draw upon when the full VA system faces the same challenges in the context of national health care reform.

Congressional action is necessary to allow VA to:

1) Offer a comprehensive set of benefits to veterans using VA medical facilities within a state.

Unfortunately, VA would not be facing this difficulty if the Congress and the Administration had agreed to enact veterans health care eligibility reform providing a standard benefit package containing the full continuum of care last year. However, that option still remains with regard to benefit packages designed for the pilot programs. As a second option, the pilot programs could offer a benefit package similar to the basic benefits in H.R. 3600, the Administration's "Health Security Act." As a third option, (not without hazard as we will discuss later) each VA facility could be authorized to offer benefits at a level no less than the level of benefits authorized under the state plan.

2) Allow VA to establish needed community-based outreach clinics necessary to attract and serve its enrollees.

The biggest adjustment for the VA system under any health care reform proposal will come in its ability to shift and expand out of its traditional role as an inpatient, tertiary provider to a health system offering the full spectrum of care including expanded primary services. VA should have additional authority and resources to lease space in the community to bring primary care services to its patient population in the same way as any other provider in the

private sector would. VA facilities should also have the authority to augment their community-based operations through contracts and sharing agreements with other providers.

3) Allow VA to contract for services.

VA facilities in these situations should not be forced to become "all things to all veteran patients." Within available resources, VA facilities should maximize those things it does best and most efficiently and send the other services elsewhere, either under contract or sharing agreement basis.

4) Allow VA to provide services to the family members of veterans, either in-house or on a contract basis.

Such authority will allow VA to match and compete with the benefit packages offered by other providers in the state in order to attract and retain veterans in the VA plan. It will also provide an additional source of revenue for the system. There is certainly nothing inconsistent with the traditional role of VA in being able to provide or manage services to the families of those who have served in defense of this nation, as long as the needs of eligible veterans retain the primary focus of the system.

The pilot program should ensure that VA facilities have the ability to create VA-state working relationships. These relationships are essential to enhance the use of existing health care resources available within a state to contain costs and make services optimally accessible. These working relationships should include:

1) Sharing excess VA resources within the state on a sharing agreements basis.

2) Establishing formal relationships between health plans operating within a state.

3) Strengthening the relationships between VA and affiliated health professions schools regarding the number and types of manpower needed to best serve the needs of VA patients.

4) Expanding opportunities for cooperative medical and health services research.

Mr. Chairman, PVA has identified three areas of concern in the process of designing pilot programs to allow VA to interact successfully and survive under individual state health care reform initiatives. These areas of concern are:

1) Designing an adequate benefit/eligibility package, while at the same time maintaining VA's ability and willingness in those states to provide the traditional additional benefits, such as care for spinal cord injury and dysfunction, that have been unique to the VA system.

Providing authority for VA facilities under these circumstances to offer a basic benefit package will, for many veterans, grant services they had not previously been eligible to receive. But basic benefit packages, whether under a state reform plan or under a national reform scenario, will also set limits on the amount of services VA facilities can provide. Various reimbursement scenarios from third parties, state or federal entities will drive individual facilities to provide services only up to the authorized level. Appropriations, under any reform plan would still be used to cover the cost of additional

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benefits, over and above the basic state or eventual federal package, that VA has traditionally provided. Such services include specialized rehabilitation, prosthetics, sustaining and long-term care for veterans with spinal cord injury and dysfunction, specialized care for other veterans with severe disabilities, blinded veterans, and extended mental health services that are unique to the VA system.

PVA is concerned that the drive for cost containment and competitiveness, coupled with an erosion in the availability of the appropriated dollar, will entice individual VA medical facilities to shrink their benefit package to the lowest common denominator and abandon or discard these additional services viewing them as a burden and not a traditional obligation of the VA mission. Over the years, VA has established a comprehensive network of centers for the treatment of veterans with spinal cord injury and dysfunction. The centers have forged a cadre of health professionals trained in the specialized care of these veterans and developed a system of sustaining and extended care, rehabilitation, research, prosthetics and orthotics for spinal cord injured veterans that is unique in the United States. Abandoning such a system would be a catastrophe for VA as well as a tragedy for veterans who look to the system to receive this specialized treatment.

We are aware that the eventual demise of the SCI system was raised in positive tones more than once at the recent VA health care reform task force meeting in Washington. Abandoning these and other specialized services, which would be over and above any state or federal basic benefit package, seems to PVA to be an alluring temptation for any VA medical center director looking to cut costs and become more "competitive.". There is no mention or authorization in title 38, U.S.C. for care for veterans with spinal cord injury or dysfunction, nor is there any reference to the existence of the VA SCI centers. We firmly believe these and other specialized programs are in danger under any health care reform scenario.

PVA strongly recommends that the Committee include a specific mandate for the continuation of these specialized services, in both the legislation that authorizes the state pilot programs as well as the final version of the national health care reform bill.

2) Determining how the service area of the facility will be drawn in order to establish who will be eligible for benefits.

Under the state reform pilot program VA will be creating islands of unique standing and eligibility within the VA system. Individual VA medical centers in certain states will have unusual freedom from regulation, unique funding sources and administrative latitude unknown in the rest of the VA system.

However, at least until national health care reform is enacted, the greatest difference between facilities in these states and other VA medical centers will rest in the enhanced benefit package they will be authorized to offer. PVA sees this situation, as an acceptable anomaly in order to respond to the state health care reform process to protect those VA facilities in those states. While it is not necessarily right, and despite mandates in title 38, there already are major differences in the availability of services from one VA to another throughout the country. These variations are the result of the density of the veteran population, availability of resources, degree of patient load, and the lack of uniform entitlement to care for all veterans.

PVA does see major problems, however, in determining how eligibility for expanded benefits within the service areas of the facilities under the pilot program will be established. One option would be to limit expanded eligibility only to those veterans residing in the state that has enacted the reforms. This would limit all out of state veterans, even those who might have the identical current eligibility for care under title 38, to a lesser benefit from the same medical facility. Such a scenario completely ignores the often regional or interstate mission many VA medical centers have, particularly in the provision of specialized services such as care for spinal cord injury or dysfunction. It establishes a gross inequity between veterans based solely on their place of residence. It also would skew the results of the pilot study by artificially limiting the pool of VA users who would naturally be in the service area of that facility.

PVA believes that the only way to proceed in this matter is to ignore the state boundaries and establish eligibility based on the traditional service area of the facility. The financial impact on VA to cover the additional benefits for these out of state veterans can be contained through an enrollment process and might even be offset completely by the loss of previous VA users who decide to enroll in non VA plans within the state once reforms are enacted. In any case, PVA believes that service area enrollment versus limitations on state boundaries are the only logical option in determining benefit eligibility.

3) Defining how, and from what source, these pilot programs will be funded.

Preliminary discussions on funding for the pilot programs call for VA to utilize existing funds from the medical care or construction account. PVA objects strongly to this concept.

The Administration's FY 1995 budget proposal will not contain enough funds to adequately support the VA system as a whole, let alone provide additional funding to support an expansion of benefits and services in a handful of areas throughout the country. In our opinion, the pilot programs are being designed to respond to a unique, near emergency situation where, without immediate action, the viability of existing VA facilities in those states would come under immediate question.

PVA urges that funding for the pilot programs come from separate appropriations in the nature of a grant program. Along these lines, the Independent Budget for FY 1995 has designed an outline for such a grant program. We would be happy to make that proposal available to the committee.

Mr. Chairman, PVA congratulates you and the members of the Committee for holding this hearing and making this issue a matter of immediate concern at the beginning of this session of the Congress. We will be happy to assist you in any way we can as you work to design this legislation.

Thank you again for your invitation to be here today. I will be happy to answer any questions that I can.

PARALYZED VETERANS OF AMERICA
801 18TH STREET, NW
Washington, DC 20006, November 12, 1993.

THE HONORABLE JESSE BROWN
Secretary of Veterans Affairs
Department of Veterans Affairs
801 I Street, NW
Washington, DC 20091.

DEAR MR. SECRETARY: On behalf of the members of Paralyzed Veterans of America (PVA), I am writing to urge the Department of Veterans Affairs (VA) to submit legislation to the Congress as soon as possible that would give VA medical facilities the flexibility to respond immediately to competitive pressures arising from health care reforms being implemented in certain states independent of the national health care reform movement. Four states in particular, Washington, Oregon, Minnesota and Florida, have either already started the process of major reform or are on the verge of doing so. Many other states are not far behind. These health care facilities would surely lose their competitive ability if they were forced to wait until passage of national health care reform to respond to changes in programs and benefits already implemented in their own states.

For the past three years, PVA has maintained an active state health care reform project. This activity continues to monitor the substance and timing for reform in each of the 50 states, many of which are way out in front of the federal health care reform initiative. (I am enclosing a copy of our updated state health reform status report for your review.) We are concerned that whatever the states do to either restrict or expand health care eligibility or services for their citizens, including veterans, will have a profound effect on patient load and resource allocation for VA medical facilities in those states. Without the ability to react to these changes, particularly in the area of eligibility, VA medical facilities would be reduced to mere mute partners, able only to "take what comes," in the competition over resources and patient share. In our discussions and communications with governors and state health policy experts we have found a troubling lack of appreciation for the dilemma VA would find itself in under this scenario. In fact, in our review of the literature and state legislative initiatives, only two states, Washington and Montana, even mention the existence of VA as a provider within their borders. We want to make certain this oversight is not repeated by legislative and health planning processes in the federal government.

For this reason, we applaud your initiative to set up a similar state health reform monitoring system within the VA Office of Public and Intergovernmental Affairs. We would like to make a firm offer of assistance to share our expertise and findings in state health care reform matters with this new effort. In addition, we recommend that all VSO's be given the opportunity to interact as full partners with VA's newly established larger task force studying the Department's overall role and reaction in national health care reform.

At the same time, as stated above, we believe it is imperative for VA to move immediately in those states that are on the verge of reform and design a legislative package that can give VA facilities in those states the flexibility to compete successfully. These pilot initiatives would certainly serve as

guideposts for later VA adaptations to reform initiatives in other states and the national health reform program as well.

Thank you for your concern in this matter. Please let us know how PVA can be of further assistance.

Sincerely,

GORDON H. MANSFIELD, *Executive Director.*

REVIEW OF 6 MAJOR STATE HEALTH CARE REFORM PLANS BY PARALYZED VETERANS OF AMERICA

—FLORIDA—

THE FLORIDA HEALTH CARE REFORM ACT OF 1992

The Health Care Act of 1992 is more of a broad outline for reform than a detailed plan. The legislation basically sets the groundwork and guidelines for later health care reforms (such as the 1993 Health Care Act) to build upon. However, in addition to recommending reform in certain areas of health care, the Act also establishes agencies such as the Agency for Health Care Administration and programs like the Florida Health Corp, which are both important additions to Florida's health care marketplace.

Under the Act, the Agency for Health Care Administration consolidates the regulatory functions of numerous state departments. The Agency's responsibilities include hospital rate regulation, facility and professional licensure, planning and hospital budget review as well as overseeing much of the reforms mandated by the 1993 health care legislation. The Florida Health Corps on the other hand, is not a regulating body, but is rather a program designed to improve access to quality health care in medically underserved areas. The Florida Health Corps will accomplish this goal by providing scholarship and loan repayment assistance to health professionals who serve in rural and other medically underserved areas.

In terms laying the groundwork for health care reform, the 1992 legislation provides the opportunity for substantial change. First, the Act mandates the development of a two-phase Florida Health Plan to provide all residents with access to an affordable basic benefit package. Phase One is a voluntary program, and Phase Two is a mandatory program, implemented only if the voluntary program is judged unsuccessful. In Phase One, employer incentives, market reform and expanded state programs are used to encourage employers to cover their workers and to provide access to insurance for other uninsured. As stated above, these reforms are voluntary: no one is mandated to participate. However, if these voluntary reforms do not meet the access goals of the state, then a mandatory state-run program will be activated which will require employer coverage, institute stricter market reforms, and further expand state assistance to low income workers and the unemployed. Detailed plans on how either Phase One or Phase Two would function are not included in this legislation, but the beginnings of how these goals will be achieved can be found in the Health Care Act of 1993.

In addition, the '92 Act also calls for the development of standardized medical practice parameters, small-business insurance reform, assurances for portability of coverage, the development of conversion policies, supplemental

Medicare insurance, long-term care insurance and the determination of the minimum standards for total disability. Many of the recommendations developed to address these health care problems have found their way into the 1993 Health Care Act, a more detailed plan for reform.

The Florida Health Care Reform Act Of 1993

Drawing on the reforms and recommendations set by the Health Care Act of 1992, the 1993 Act institutes concrete programs and reforms that, according to Governor Chiles "will make health care accessible and affordable to all."[1] The major aspects of the Act include the creation of 11 regional health purchasing pools, the establishment of a low income insurance program, and expansion of the Agency for Health Care Administration. For now, participation in Florida's health care reforms are voluntary, and impose neither price controls nor employer mandates.

Each of the 11 regional purchasing pools (known as Community Health Purchasing Alliances or CHPA's) will be non-profit organizations which will be headed by 17 member boards of directors, and are scheduled to go into effect by April 1, 1994. The CHPA's will not provide insurance themselves, but will, like most managed competition plans, contract with state certified insurance plans (known as Accountable Health Partnerships or AHP's) to provide service to members. In addition to purchasing leverage, the CHPA's will provide information to members concerning the price, quality, patient satisfaction, and enrollee responsibilities of the AHP's. Due to a compromise between Governor Chiles and providers, insurers and other politicians, membership in the CHPA's will be limited to those who receive their coverage from the state; individuals; Medicaid recipients; and small businesses with fewer than 50 workers. However, any person or business will have access to the information services provided by the CHPA's.

For those low income Florida residents who need additional help in affording coverage, the 1993 Act creates a state insurance program known as MedAccess, and plans later for a Medicaid Buy-In program which will be established if the state can obtain the proper federal waivers. MedAccess will be offered to Floridians with gross family income that is equal to or below 250% of the federal poverty level and who are not already eligible to receive Medicare or Medicaid benefits. It will offer a basic benefits package that will emphasize primary and preventive care. Premiums and copayments will be paid for by individuals and employers, and MedAccess members will add their buying power to the CHPA's. If the state can obtain federal approval then Florida would offer the Medicaid Buy-In program to individuals at or below 250% of the federal poverty level and would (unlike Medicaid) use income as the sole eligibility criterion. Combining with current Medicaid beneficiaries, the Medicaid Buy-In program would then be the sole publicly supported health insurance program for low income residents. With the implementation of the Medicaid Buy-In program, MedAccess would most likely become a publicly sponsored commercial insurance program which would offer small businesses a low-cost health insurance alternative.

The 1993 Health Care Act expands the responsibilities of the Agency for Health Care Administration. Under the 1993 Act, the Agency becomes responsible for developing state practice parameters, producing a standardized

claim form for providers and insurers, establishing statewide benefit standards and supervising the CHPA's.

Small businesses and medically underserved areas also stand to benefit from the 1993 reforms. The Act prevents the tying of the price of health care coverage for small companies to the health of their employees. Insurers will no longer be able to base premiums for firms with 50 or fewer employees on the medical condition of the workers, or on the jobs they perform. The 1993 Act requires insurers to use a modified community rating — setting premiums adjusted only on the basis of geography, sex, age, family composition, and tobacco use. For the improvement of health services in rural regions, the Act calls for the development of rural health networks and special work groups to investigate health problems in medically underserved areas.

The Florida Health Care Reform Act of 1993 is not a universal access health care plan. As stated above, the reforms, for the most part, are voluntary, and thus will not include everyone who could, or should receive health care. If the Act fails to provide adequate change in the health care marketplace, mandatory regulations will follow. Proponents of the 1993 Act hope that mandatory controls will not have to be implemented, but many feel that is exactly what must happen.

—MINNESOTA—

The Minnesota Health Right Act (MinnesotaCare Part 1)

Enacted in April 1992, this large piece of legislation calls for several major health reforms. Most notably, the Act establishes the MinnesotaCare program; sets reforms in the small business insurance market through the Minnesota Small Employer Health Benefit Act and the Minnesota Employers Insurance Program; and calls for malpractice reform. In addition, the Act also establishes reform initiatives concerning rural health, health professional education, and data collection and research.

The Act requires the Health Commissioner to establish statewide and regional limits on growth in health care spending. The Minnesota Health Care Commission is also directed to submit a plan to slow the growth in health care spending. The goal of the plan must be to reduce the health care inflation rate by at least ten percent a year for the next five years. The cost-containment measures include limits on new and existing technologies, the institution of mandatory practice parameters, outcomes research to identify appropriate and inappropriate spending, designated "centers of excellence" as the only sites where certain procedures may be performed, designated volume minimums for procedures, and a public education campaign to improve and increase individual responsibility for personal health. Much of the cost containment strategies are found in the 1993 MinnesotaCare Legislation (see below).

The MinnesotaCare Program is a state subsidized health care plan for low income state residents who do not qualify for Medicare or Medicaid and have no access to subsidized health insurance from their employer. The Program offers a basic benefit plan delivered through a managed care organization and ensures community rating and guaranteed eligibility. The financing for the plan comes from a five cent increase in the state's cigarette tax and provider taxes. Out-of-state hospitals which serve more than 20 Minnesotans a year are also subject to the tax, a fact to which they obviously object. While providers

dislike the program because of the provider taxes, the MinnesotaCare Program has drawn much public and government support. The Program will also serve as a test population of sorts for future health care reform, as it will be one of the first publicly funded groups to be brought into the Integrated Service Networks that were created by the 1993 MinnesotaCare legislation (see below).

The 1993 MinnesotaCare Act

The 1993 Legislation is the second part of the ongoing development of the MinnesotaCare Plan. The 1993 edition adds more detail to the 1992 plan of increasing health care access while controlling costs. Most importantly, health care networks known as Integrated Service Networks (ISN's) are created and regulated by the state to provide cost control. Provider participation in these ISN's is not required, but providers that do not join ISN's will become part of a more restrictive All-Payer System. The ISN's will help to control costs by including all health care at a capitated rate, while the All-Payer system will work in a similar way, instituting a uniform fee schedule or rate structure to control costs. The Commissioner of Health is charged with establishing up to 5 standard ISN benefit plans which will encompass a range of cost sharing options. In addition, the ISN's will be obligated to offer health care coverage to all state residents and cannot refuse coverage to any individual or group on the basis of preexisting conditions or other risk factors. Officials anticipate that the networks will be similar to HMO's, but with budget caps. Many of the details concerning the ISN's and the All-Payer System have yet to be worked out before the targeted operation date of July 1994.

The importance of cost control is attributed to the annual state-wide growth limits on health care that is mandated by the MinnesotaCare Act. The goal of the plan is to reduce the current rate of health care growth by ten percent per year. Beginning in 1994, growth limits for health care will be tied to the growth in the Consumer Price Index plus a decreasing percentage, until 1999, when health care growth will mirror the increase of the Consumer Price Index exactly. To accomplish this goal, the Commissioner of Health will impose and enforce growth limits and maximum cost charges on the ISN's and the All-Payer System.

The MinnesotaCare Plan is an evolving program, and the 1994 State Legislature will provide more operational details. Integration of federal programs into the ISN's and All-Payer system seems likely — whether through state mandates or needed federal flexibility. While the MinnesotaCare plan does not contain any individual or employer mandates, state officials hope that the instituted reforms (a re-organized delivery system; individual and small market insurance reforms; expansion of insurance programs for low income residents) will bring about near-universal coverage.

—OREGON—

The Oregon Health Plan

The Oregon Health Plan is state's attempt at providing its citizens with near-universal access to health care. Known primarily for the prioritized list of medical procedures (or "rationing experiment", according to critics), the Oregon Health Plan consists primarily of three laws passed in 1989: the Oregon Basic Health Services Act (SB 27); The Health Partnership Act (SB 935) and the

Oregon Medical High Risk Pool (SB 534). The Plan also includes a small business insurance law passed in 1991 (SB 1076) and a 1993 final implementation law (SB 5530).

The Oregon Basic Health Services Act reorganizes the state's Medicaid system. First, the Act extends benefits to 100% of the federal poverty line, adding an estimated 120,000 residents to the 243,000 residents already receiving Medicaid benefits. Funding for these added recipients comes from the restructuring of the benefits program. Developed by an eleven-member Health Services Commission, the new benefits program is a prioritized list of 696 "condition/treatment pairs" ranked on the basis of effectiveness and cost-efficiency. Based on funding estimates, the top 565 condition/treatment pairs will be covered under the plan. These covered benefits encompass a wide range of treatments — including most of the original Medicaid benefits plus many others. The benefit lists will continue to be refined — new lists, including funding cut-offs will be developed every two years by the Health Services Commission.

The Health Partnership Act is Oregon's "play or pay" employer mandate. Originally scheduled to go into effect for all businesses on July 1, 1995, the mandate has been postponed to April 1997 for large businesses and to January 1998 for small businesses, and may be repealed altogether. If the state is unable to obtain a federal ERISA waiver by January 1, 1996, then the employer mandate portion of the Oregon Health Plan will be removed. If the mandate does go into effect, it will follow the classic "play or pay" model where businesses either offer insurance to their employees or they pay a surcharge to fund a pool for subsidizing uninsured workers.

Two other bills work to provide affordable insurance to certain populations. The medical high risk pool (SB 534) was created to provide health care to otherwise uninsurable residents. The state shares the financial responsibility with insurers for the coverage of the medically uninsurable, and participants pay no more than 150% of a standard premium. SB 1076 requires small business insurers to guarantee issue and renewal, practice modified community rating and to offer a small employer basic health plan.

After years of wrangling and debate, the Oregon Health Plan finally made it through its last hurdle on September 14, 1993 with the passing of SB 5530. SB 5530, spurred on by the granting of a federal waiver in May of 1993, implements the Oregon Health Plan and includes the ERISA provision concerning the employer mandate (above). Battle over the ERISA waiver is expected to be intense over the next two years, with employers focusing their lobbying targets on federal, rather that state legislative leaders. If the employer mandate is not enacted, the state will fall far short of their near-universal access plans, however, thanks to the Medicaid and small employer reforms and the establishment of the medical high risk pool, Oregon will continue to be a leading state in health care reform.

—TENNESSEE—

TennCare

Facing an estimated $764 million Medicaid shortfall and approximately 780,000 uninsured state residents, Tennessee Governor Ned McWherter spent most of 1993 pushing for a major overhauling of the current government

system of providing health care for the poor. Instead of slashing benefits, raising taxes or trimming Medicaid enrollment, McWherter's office developed the TennCare plan. TennCare places the state's Medicaid population (except for nursing home services) into managed care plans.

Officials claim that TennCare, which received a federal Medicaid waiver from HCFA on November 18, 1993, will eventually be able to cover an additional 500,000 low income residents who are currently uninsured, at no additional cost. Proponents believe that the funds to cover the additional residents will come from the savings that the state receives from shifting Medicaid recipients into managed care organizations. With waiver in hand, the state has already begun to implement the program since its official opening on January 1, 1994.

In addition to public funds, the plan calls for certain financial involvement on the part of the enrollees. Premiums and co-payments will be determined by family income. Those with family income below 100% of the poverty line (including current Medicaid recipients) receive free care, those between 100% and 200% of poverty contribute on a sliding scale, while those over 200% of poverty pay a flat 20% and $1,000 deductible towards their care. As an incentive to stay healthy, deductibles and copayments are waived for both preventive services, and for prenatal care for women earning up to 200% of the poverty level.

Enrollment in TennCare is limited to only current Medicaid recipients and those who were uninsured as of March 1, 1993, to make sure that residents do not dump their current insurers to join the state-supported plan. There are also provisions in the legislation that makes it clear that Medicaid's `spend down' requirements does not apply to prospective TennCare enrollees. Of concern to veterans was an eligibility provision which stated that "anyone who is or becomes eligible for another federal program, such as Medicare, and would not also meet the eligibility requirements for Tennessee Medicaid and would not be covered."[2] "Another federal program" was taken to include resident veterans eligible for VA care. State officials, however, did not take into consideration VA's complex eligibility/entitlement rules and assumed that every veteran receiving services through VA was given comprehensive medical care. The state has since reversed itself, no longer considering access to the VA hospital system in TennCare eligibility criteria.

—VERMONT—

Vermont Health Care Act of 1992 (Act 160)

The Health Care Act of 1992 creates the Vermont Health Care Authority (VHCA) directed to develop two alternative universal access health care systems — a single payer system and a regulated multiple payer system. On November 1, 1993 the Authority unveiled their two systems for consideration by the 1994 state legislature. Each plan was required to, and included, several provisions: universal coverage emphasizing preventive care; encouraged enrollment in provider networks, global budgeting, a standard benefits package, cost containment incentives, portability of benefits, a provider reimbursement system and recommendations for including long term care at a future date.

In addition to mandating the development of the universal access plans, the Act also calls for the incremental adoption of a binding Unified Health Care

Budget by July 1, 1994. The budget will consist of the total amount of money to be spent of all services provided by health care facilities and providers in the state, and will function as the main provision for controlling health care costs in Vermont. Other market reforms are also included. The act extends the state's small business community rating law to individuals and also expands the state' Dr. Dynasaur program for low income children up to age 18. Malpractice reform, primary care physician training initiatives and the establishment of Integrated Networks of Care are also part of the legislative package.

—WASHINGTON—

On May 17, 1993 Washington State Governor Mike Lowry signed into law the Washington Health Services Act of 1993, a package of legislation that has been called "the most comprehensive health care reform bill adopted by any state".[3] Full implementation of the Act, however, will require the various federal waivers in order to include Medicare and Medicaid recipients. In addition, the Washington State Legislative Committee will also study how to consolidate federal programs such as VA, CHAMPUS, etc. under the state purchasing agent.

The Health Services Act promises universal coverage to all Washington residents by July 1, 1999. The Act, which is basically a managed competition plan with price controls, creates a Uniform Benefit Package of services for which all residents will be covered. The exact contents of the Uniform Benefit Package will be determined by a five member committee, known as the Health Services Commission, who will also set a maximum premium that could be charged by insurers for the Package. Each state resident will be required to purchase the Uniform Benefit Package at a minimum by 1999.

Payment of health care premiums will be accomplished in several ways. First, all employers of full-time (30+ hours per week) workers will be required to pay at least 50% of the lowest priced premium offered, while employers of part-time workers will pay a pro-rated percentage of the health care premium based on the hours their employees works. Small businesses and low income workers will be eligible for certain state assistance in paying their premium shares. The unemployed will, for now, (until or if a federal waiver is procured) be covered by an expansion of existing government programs (such as Medicaid, and Washington's Basic Health Plan and First Steps program), that will be funded by an increase in taxes (mostly provider and "sin" taxes). Also, large businesses (7,000+) will be able to offer benefits to their employees, as long as their plans meet most of the requirements that apply to the Certified Health Plans.

The Act calls for the creation of four Health Insurance Purchasing Cooperatives (HIPC's) for the general public and a Consolidated State Purchasing Agent (CSPA) for those residents who receive their coverage from the state. If the state is able to obtain the proper waivers, Washington would also like to include federal programs such as Medicaid, CHAMPUS and Veteran Services in the Consolidated State Purchasing Agent. These large purchasing pools will contract with the state's Certified Health Plans (CHP's) to obtain the best prices available by using their combined consumer clout. By 1995, all insurers in the state must be Certified Health Plans. To become a CHP, an insurance group must be approved by the Health Services Commission which requires that each plan be a managed care organization, include the

Uniform Benefit Package, and offer the Package under the established premium cap. In addition, the CHP's must practice community rating, accept everyone that applies (regardless of age, health status, etc.), cannot cancel or refuse renewal of coverage and also cannot balance bill or charge extra fees for services included in the Uniform Benefits Package.

Insurers will compete with each other by offering the Uniform Benefits Package to consumers for rates under the established premium cap. Insurers may also compete for enrollees by offering additional covered services which supplement the Uniform Benefits Package. Maximum premiums for this additional coverage will also be set by the Commission.

In addition to a managed competition approach, health costs will be controlled by several other measures. First of all, beginning in 1996, the rate of increase in the maximum premium will be reduced by two percentage points per year until it equals the rate of growth in Washington State's per capita income. Health plans will also be coordinated so that no person is covered by more than one plan, thereby streamlining billing and claims procedures. Malpractice reform, focusing efforts on primary rather than emergency care, and using copayments and coinsurance to limit consumers' use of unnecessary services, are more cost control measures that are included in this reform package.

In order to successfully ensure that all residents receive adequate coverage, the Washington plan includes provisions to increase the number of primary care physicians and access to health care for those residents in medically underserved areas. The Act provides incentives such as scholarship and loan repayment programs that will be offered to University of Washington graduates who enter primary care residency programs. In addition, medically underserved areas will be allowed to "sponsor" students who will practice in their communities. The state government will also help by creating area health centers and establishing more residency programs in medically underserved areas.

While the Washington Health Services Act has received much political support, there are also critics who question the affordability of the reform program. Small and mid-sized insurers fear that they will be priced out by the large insurance companies and small-businesses are still concerned about their ability to purchase health insurance despite promises of state aid. While the Washington plan promises universal access to health care, the plan does not include one group: migrant workers, a fact which most farmers object to. Despite these concerns, the legislation successfully made it through the state hurdles to become law. Now the Act faces its greatest obstacles, namely the federal waiver process and the program's smooth implementation.

Notes:

1. *AHA News,* April 12, 1993: p.1.

2. TennCare application for Section 1115 Demonstration Waiver to the Department of Health and Human Services, June 16, 1993.

3. *AHA News,* May 3, 1993.

PARALYZED VETERANS OF AMERICA
Health Policy Department

State Health Care Reform Efforts

JULY 1994

Table of Contents

Foreword

PVA, Spinal Cord Injury, VA, and State Reforms

Since its incorporation in 1947, PVA has served dual roles, as advocate to veterans and advocate to disabled populations. While other veterans' service organizations have concentrated solely upon veteran concerns, PVA has focused on disability issues with as much commitment. Whether working for passage of the *Americans With Disabilities Act (ADA)*, funding spinal cord research, or formulating health policy, PVA has worked to better the lives of our members, other veterans and those living with spinal cord dysfunction.

Veterans' and disability issues most closely intertwine as they relate to the VA health care system. VA has long led in rehabilitation and support services for veterans with spinal cord injury and disease. VA's programs, equipment, and expertise in dealing with spinal cord injury's long-term consequences are simply not found in the private sector. For many of PVA's members, VA is the preferred - or sometimes the only - choice for receiving specialized care. In addition to the physical services it provides, VA has pioneered spinal cord injury research. Its breakthroughs benefit not only veterans, but the general public as well. Thus, a continued, strong VA health care system is important to PVA, its members, and other spinal cord injured citizens.

States also benefit from VA's existence. VA employs approximately 200,000 health care workers nationwide, and provided $15.5 billion worth of care in Fiscal Year 1993. By caring for medically indigent and high-risk veterans VA saves states billions of Medicaid and uncompensated care dollars each year. VA's extensive nursing home and long term care services further reduce the drain on state assistance programs.

Nationally, VA provides one-third of the country's care for the chronically mentally ill. VA is also the nation's largest source of health care for AIDS-related disorders and VA has broad-reaching programs for the homeless— one-third of whom are veterans. Finally, VA exists as a back-up medical system to the Department of Defense during times of national emergency or crisis.

Despite the contributions of this national resource, state policy-makers tend to ignore VA when developing their reform programs. State officials rarely understand fully how the VA medical system works, especially concerning its complex eligibility and entitlement rules. Policymakers may exclude VA users from state reform programs that offer richer benefit packages than VA is able to provide. State officials are also reluctant to tangle with the Federal government to include VA in their reform efforts. Rather than developing needed federal waiver requests, policymakers often design their reform plans around VA or ignore VA altogether, believing that VA will continue to operate in their states. The truth is that VA cannot survive alone in the "jungle" of state health care reform. To ensure VA's continuance, legislators must make VA a full partner in their state health care reforms.

State reform plans are also important to the disabled community. PVA is particularly concerned that state health plans may not adequately address the needs of spinal cord injured individuals. For example, state-mandated benefit packages may not cover needed services or may strictly limit them. State health care reforms may not address the catastrophically disabled's overly high premium costs and copayments. Without regulations, insurance companies may use numerous techniques to discourage high-cost populations from enrolling. Insurers can institute pre-existing condition exclusions, refusing to cover current or previous medical conditions, or extend waiting periods for coverage. Insurers are often free to deny coverage to high-risk populations (known as "cherry-picking") or charge these groups inflated prices for coverage. In addition, state health reforms rarely address long term care, which serves as an umbrella various programs imperative to meeting disabled populations' needs. These concerns have prompted PVA to closely follow state, as well as federal, health care reform efforts.

This publication has three goals:

- To make persons aware of the extent and types of state health care reforms— that is, to emphasize that health care reform is not just under discussion at the federal level.
- To make legislators aware that state reforms have largely ignored VA, a large, and important piece of the health care puzzle. VA must be included in state reform efforts if it is to survive.
- To make state legislators aware of the needs of the requirements the catastrophically disabled, the population most in need of health care reform.

Future editions of the Matrix will attempt to analyze whether states have adequately addressed the needs of the spinal cord injured and other catastrophically disabled residents.

Background

This state health reform matrix is a product of Paralyzed Veterans of America's (PVA) State Health Policy Project, a five-year-old program responsible for tracking health issues at the state level and assessing their impact on veterans and the VA health care system. PVA began the project to evaluate the 1988 Massachusetts Health Security Act effect on the VA system. The Massachusetts Health Security Act would have greatly expanded the state's residents' health care coverage by mandating that employers either provide health insurance to their workers or contribute to a state fund on worker's behalf.

PVA staff recognized that this type of financing mechanism would offer some veterans a choice of sponsored coverage they had not previously had. Some veterans, who may have been using VA because they lacked a cost-competitive alternative, could now choose other care providers. PVA staff believed this newfound opportunity to choose could potentially affect VA health care utilization—perhaps drastically. PVA wanted to identify how this type of choice would affect utilization and, consequentially, how VA facilities in the state would react to the impact.

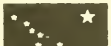
Though the Massachusetts reform plan's implementation has encountered major barriers, its potential impact on veterans and the VA health care system within Massachusetts motivated PVA to carefully monitor state health reform efforts. Subsequently, PVA expanded the State Health Policy Project to monitor other states considering health care reform. Today, the Project daily tracks health care reform issues on and maintains a database and library on all 50 states, the territories and the District of Columbia.

State Health Care Reform Matrix

This matrix briefly summarizes major state health care reforms, initiatives and commission studies. It also reviews state health care reforms' impact on VA and disabled populations and federal legislation that would allow VA to establish pilot projects in states actively pursuing health care reform.

The matrix is updated periodically, as states introduce and adopt new legislation. This year numerous states have already forged ahead in an effort to craft plans more suitable to their own demographics. Changes in the matrix will attempt to keep pace with the states' rapid progress in considering and enacting significant health care reform. Interested parties may obtain updated copies of the matrix by contacting PVA Health Policy Department at 1-800-424-8200.

State Health Care Reform Efforts

State	Enacted Reforms	Major Reform Proposals and Commission Studies
ALABAMA 	*Alabama Insurance Board (S.B. 8)* A 12-member board created to negotiate group health insurance coverage for residents who wish to acquire it. Includes no government subsidies.	*Alabama Patients Access To Health Care (A-PATH)* A managed care program for the state's Medicaid recipients. The state has submitted a Medicaid waiver request to the Health Care Financing Administration (HCFA) for approval. *Governor's Health Care Task Force* Appointed by Governor Jim Folsom, the Task Force meets every three to four months, and will submit its health care reform recommendations to the 1995 Legislature.
ALASKA 	*Chapter 39* Creates the Small Employer Health Reinsurance Association and several small business reinsurance pools. The Association is charged with developing two types of standard benefit packages for small businesses, and establishing the maximum rate insurers can charge for the packages. In addition, the Association is responsible for developing cost containment strategies, limiting the use of pre-existing conditions and setting regulations regarding health care coverage renewability and portability *CHOICE (Community and Home Options to Institutional Care for Everyone) Program* Granted a three-year demonstration waiver from the Health Care Financing Administration (HCFA), the program offers home and community-based services to certain elderly and disabled populations who would otherwise require institutional care. The program began on July 1, 1993 and the state expects to cover approximately 550 people. *Medical High Risk Pool* Established in 1992, the pool makes insurance coverage available for residents who do not qualify for other insurance because of their medical conditions.	NONE.
ARIZONA 	*Arizona Health Care Cost Containment System (AHCCCS)* Established in 1982, this is a competitively bid, capitated health program for Medicaid-eligible and other indigent citizens. A Medicaid waiver allows the state to place participants into private, managed-care organizations. The waiver, however, will expire on October 1, 1994, and state officials are pushing for either a waiver extension, or for AHCCCS to become a permanent program. *Medical Savings Accounts* Enacted in 1994; allows residents to establish tax-free medical savings accounts to pay for qualified medical expenses.	*Arizona Affordable Health Care Foundation* A coalition of business, insurance, providers, consumers, public officials and organized labor which has developed and advocates for a comprehensive health care reform program based on a version of the managed competition model

State	Enacted Reforms	Major Reform Proposals and Commission Studies
ARIZONA Continued	*Small Group Market Reforms* Insurers must issue and renew their policies to any small group that applies, regardless of health condition or risk. Pre-existing condition exclusions are also limited and rating restrictions control premium variation between groups. In addition, insurers must offer a basic health plan to qualified small employers.	
ARKANSAS	*The Uninsured Children's Program* Signed into law in March, 1989, the program provides primary health care services to uninsured children living in families earning up to 185 percent of the federal poverty level. *Small Group Market Reforms* Insurers must guarantee policy renewal to small groups. Rating restrictions limit the difference between the lowest and highest premium rates for different employer groups with similar risk characteristics.	*Arkansas Health Resources Commission* Created in 1993, the Commission is charged with studying a number of health issues such as cost containment and expansion of coverage. The Commission's final report is due by January, 1995. *Project Access Task Force* Formed by Governor Tucker and funded by a Robert Wood Johnson Foundation grant, the Task Force is responsible for developing state-level reforms and for preparing the state for interaction with possible federal health care reforms. The Task Force's final report is also due by January, 1995.
CALIFORNIA	*The California Public Employees Retirement System (CalPERS)* CalPERS provides health coverage for state and local government workers, their family members and retirees. Based on a managed-competition model, the system pools its enrollees and offers them a choice of competitively bid health care plans, which must offer at least a basic benefits plan. The program has controlled prices, negotiating a 1.1 percent decrease in premium costs for 1994. *The Health Insurance Plan of California (The HIPC)* A voluntary, state-wide, small business health insurance purchasing pool which began operation on July 1, 1993. The HIPC determines which plans can participate and negotiates rates. Approved plans must offer at least a basic benefit plan and must adhere to the small market reforms the legislation also established (see below). *Small Group Market Reforms* Guarantees policy issuance and renewal, limits exclusions based on pre-existing conditions, and allows workers to carry insurance from one job to another. Requires modified community rating, which limits premium adjustments due to health experience or status, but allows adjustments based on age, gender or industry. *Access to Infants and Mothers (AIM)* A program to provide comprehensive health coverage to low- and moderate-income pregnant women and infants younger than two. The state subsidizes the program and enrollees pay premiums and copayments. *Medi-Cal Managed Care* The state is continuing its push to place its Medicaid population into managed care organizations. California now has more Medicaid enrollees in managed care than any other state.	*The California Health Security Act* A universal access, single-payer plan promoted by a coalition of 16 labor unions and advocacy groups known as Californians For Health Security. The program would provide each resident (including the state's six million uninsured) with comprehensive medical services, including long term care, mental health benefits and prescription drug coverage. Under the plan, Medicare, Medi-Cal and private insurance would no longer exist, all residents would receive services under the system. Existing medical funds, a payroll tax, and an income surcharge would finance the program. The coalition collected more than one million signatures needed to place the Act on the November, 1994 ballot, thus bypassing the legislative process and special interest lobbying. *The "Garamendi Plan"* A universal access proposal developed by insurance commissioner John Garamendi. Closely resembles the Clinton Administration's managed competition model, with health insurance purchasing cooperatives, a basic benefits package and private competing health plans to deliver care. The plan would also provide "24-hour coverage", folding into one system all health care coverage, including Worker's Compensation and the health portion of automobile insurance, thereby reducing administrative expenses and using the savings to increase access. Another major aspect of the plan is a global budget to control health care costs and limit growth. Governor Pete Wilson opposes the plan and vetoed it in 1992, however, Garamendi continues to push for its adoption.

State	Enacted Reforms	Major Reform Proposals and Commission Studies
CALIFORNIA Continued	*Major Risk Medical Insurance Program* The state's high-risk pool; makes insurance available for people who do not qualify for insurance because of their medical conditions.	*The California Partnership for Long Term Care* Part of a four-state demonstration project supported by the Robert Wood Johnson Foundation (RWJ). Will allow people to shield their assets from Medicaid "spend-down" requirements by buying a private, state-approved, long term care insurance policy
COLORADO	*Health Care Coverage Cooperatives* Legislation enacted in 1994 allows small businesses and individuals to develop voluntary health insurance purchasing pools. A minimum benefit standard for the Cooperatives will also be established. *Medical Savings Accounts* Enacted in 1994, allows residents to establish tax-free medical savings accounts to pay for qualified medical expenses. *Small Group Market Reforms (H.B. 1210)* Enacted in 1994, establishes numerous insurance reforms for businesses with 50 or fewer workers. Small market insurers must guarantee issuance and renewal of their policies, limit the use of pre-existing condition exclusions and practice modified community rating, varying premiums only on the basis of age, family composition or geography. Insurers must also offer two standardized benefit plans to each business group. *Colorado Uninsurable Health Insurance Plan* The state's high-risk pool; the plan offers coverage to residents who find insurance unavailable to them because of their medical conditions.	NONE Although a comprehensive health reform program, ColoradoCare, received much attention throughout 1993, the plan was put on hold indefinitely. The state has decided to wait for the federal health care debate to run its course before attempting to implement their own universal reform plan. ColoradoCare was not introduced to the 1994 State Legislature.
CONNECTICUT	*Connecticut Partnership For Long Term Care* Part of a four-state demonstration project supported by the Robert Wood Johnson Foundation. Allows people to shield their assets from Medicaid "spend-down" requirements by buying private, state-approved, long term care insurance policies. *Small Group Market Reforms* Guaranteed policy issuance and renewal for small groups, restrictions on pre-existing condition exclusions; establishment of basic benefit plans for small businesses. 1993 reforms enacted modified community rating for small groups, created a low-cost basic benefit plan for individuals and established rules to allow unrelated small employers to form pools to buy insurance. *Medical High-Risk Pool* One of the first state high-risk pools; offers affordable health coverage to medically uninsurable residents.	*Office of Health Care Access* Established during a 1994 special legislative session, the Office is responsible for designing a comprehensive state health plan which will provide coverage to all state residents. The Office will also develop a minimum benefit package for the state. The plan must be completed by January 1995 and must provide all state residents access to health care by January 1997.

State	Enacted Reforms	Major Reform Proposals and Commission Studies
DELAWARE 	*Small Group Market Reforms* Guarantees policy issuance and renewal for small groups, controls premium variation between groups by restricting rating practices, and prohibits new pre-existing condition requirements for enrollees moving from group to group *Children's Health Program* A program funded jointly through the state and the Nemours Foundation offers capitated managed care to children younger than 18 living in low- income families. Those below 175 percent of poverty are provided free care, those above 175 percent of poverty pay on a sliding scale. Services are provided through the E I. Dupont De Nemours Children's Clinics	*Delaware Health Care Commission* Established by the Governor in 1992, the Commission has been working on a comprehensive reform plan for introduction late in the 1994 legislative session
FLORIDA 	*Florida's Health Care Reform Acts of 1992 and 1993* The first two stages of the state s attempt to provide universal coverage to its residents. Creates a managed competition-type system with 11 regional Community Health Purchasing Alliances (CHPAs) that will bargain with Accountable Health Plans (AHPs) to provide lower group and individual rates. Employer participation in the system is voluntary for now, however if the state does not reach its health care access goals, then mandatory regulations will go into effect, perhaps as early as January, 1995. Also creates the Agency for Health Care Administration to direct the state s health care reforms, and programs to improve primary care in underserved areas. In addition, small market reforms such as guaranteed issuance of policies, limits on pre-existing conditions and modified community rating are also included *Florida HealthAccess* A purchasing pool established in 1988 to help small businesses offer affordable health insurance. Employers must pay 50 percent of worker premiums and government subsidies reduce costs *Florida Health Service Corps* An incentive program designed to attract health professionals to medically underserved areas *Medical High Risk Pool* Makes health coverage available for people who do not quality for insurance because of their medical conditions	*Florida Health Security Program* A Medicaid reform plan which would enroll current recipients into managed care plans while expanding eligibility to low to middle class residents. The available managed care plans would be contracted through the state s Community Health Purchasing Alliances (CHPAs) and subsidies would be financed through Medicaid savings. The Governor estimates that up to 1.1 million of the state's 2.5 million uninsured could receive coverage by the program within three years. The program must receive both federal approval, in the form of a Medicaid waiver (filed in February, 1994), and state legislature approval to implement the program. However, the state legislature was unable to pass the program on two separate occasions this year - during its regular session and during its special June health care session. Nevertheless, if the federal government does approve the waiver request, the Governor could call another special legislative session for either August or September
GEORGIA 	*The Georgia Basic Health Plan* Established in 1993, this is a "bare bones" basic benefit plan aimed at low- income, uninsured residents *Georgia High Risk Health Insurance Plan* Established in 1989, offers comprehensive insurance coverage to residents who are unable to obtain health insurance at standard rates because of their medical conditions	*Governor's Commission on Health Care Reform* Established by Governor Miller in March, 1993, the Commission meets regularly to discuss health care issues and to recommend reforms

State	Enacted Reforms	Major Reform Proposals and Commission Studies
HAWAII 	*Prepaid Healthcare Act of 1974* Mandates employers of all sizes to provide health care coverage for their full–time workers. After a long legislative battle, the state finally secured an ERISA waiver in 1983, making the Act permanent. *The State Health Insurance Program (SHIP)* A state–subsidized health insurance plan for residents living below 300 percent of the federal poverty level who are not eligible for any other insurance program. Includes a basic health plan, focused on primary and preventive care. Enrollees pay premiums on a sliding scale. *HealthQuest* A managed–competition plan that will group the state's Medicaid recipients (except for the elderly and disabled) into a single, large purchasing pool. The pool will contract with insurers to provide covered medical and dental benefits. The state also wants to fold enrollees of the SHIP program into HealthQuest, pending approval from the Legislature. Hawaii received a Medicaid waiver in 1993 to implement the system.	NONE. Approximately 98 percent of Hawaii's residents have health care coverage. Expansion of the HealthQuest program may cover the small percentage that are uninsured
IDAHO 	*Small Employer Health Insurance Availability Act (S.B. 1039)* Signed into law in March 1993, enacts several small group market reforms. Insurance companies are required to offer at least two standardized benefit plans to any small business that applies, regardless of their employee's health status. In addition, premium rates are restricted from exceeding more than 20% of the usual rate charged to other groups, and the use of pre–existing condition exclusions is limited. *Individual Health Insurance Availability Act (S.B. 1552)* Signed into law in April 1994, extends the provisions enacted by the Small Employer Health Insurance Act (above) to individuals. *Medical Care Savings Accounts* Enacted in 1994, allows residents to establish tax–free medical savings accounts to pay for qualified medical expenses.	*Idaho's Health Insurance Task Force* Was continued in 1993 to study cost containment and proposed coverage for Idaho's uninsured and uninsurable. Will recommend legislation to the second session of the 1994 legislature.
ILLINOIS 	*"Bare Bones" Plan* The state has set up a low–cost, basic benefit package for small employers. *S.B. 830* Establishes a task force to implement universal billing and claims forms for both health and life insurance. *Medical High Risk Pool* Makes health coverage available for people who do not qualify for insurance because of their medical conditions.	*Illinois Health Care Reform Task Force* Established by the Governor in 1992, the Task Force is charged with developing and recommending reforms to the state legislature. *Medicaid Managed Care* One of Governor Edgar's primary legislative goals this year is to move the state's Medicaid population into managed care arrangements by April, 1995

State	Enacted Reforms	Major Reform Proposals and Commission Studies
INDIANA 	*CHOICE (Community and Home Options to Institutional Care for the Elderly and Disabled) Program* Offers an alternative to institutionalization by providing in-home services to the elderly and disabled. Beneficiaries pay for services as they are able, using private insurance, Medicare and Medicaid resources before using CHOICE funds. *Indiana Long Term Care Program* Allows elderly to legally shelter their assets so they do not have to "spend down" to qualify for long term care under Medicaid. The program allows one dollar of assets to be protected for every dollar of insurance bought. *Small Group Market Reforms* Provides rating restrictions to control the premium difference between groups with similar risk conditions. Prohibits cancelling insurance before renewal date, but does not guarantee renewal. *Indiana Comprehensive Health Insurance Association* The state's high-risk pool, offers affordable health coverage to residents who are considered medically uninsurable.	NONE.
IOWA 	*S.F. 380* Signed into law in June, 1993, allows the state to experiment, on a limited basis, with managed-competition as a precursor to later health reform. It authorizes the Director of Public Health to draft rules establishing a system of Health Insurance Purchasing Cooperatives (HIPCs) to bargain with Organized Delivery Systems (ODSs). The plan will follow a managed- competition model. *Small Group Market Reforms* Guarantees policy issuance and renewal for small businesses, provides rating restrictions to control premium variation between groups and prohibits pre-existing condition requirements for enrollees moving from group to group. Also requires insurers to offer lower-cost basic benefit plans to small businesses and to group small businesses together for rate setting. *Medical High Risk Pool* Makes health coverage available to people who do not qualify for insurance because of their medical conditions.	*Iowa Health Care Reform Project* Launched by the Governor in early 1993, the Project assisted in formulating several 1994 bills and will also work with the legislature further on comprehensive health care reforms. The Project is also responsible for advising on the development of S.F. 380.
KANSAS 	*The Kansas Uninsurable Health Insurance Plan* Allows medically uninsurable residents capable who can pay for insurance, but unable to find insurers willing to provide coverage, to purchase either low-option or high-option health plans. *Small Group Market Reforms* Insurers must guarantee issuance and renewal of their health care policies to small businesses with three to 50 employees. Rating restrictions are also applied to control premium variation between groups and pre-existing condition exclusions are limited to a period of 90 days. In addition, insurers are required to offer a basic benefit package to small businesses.	NONE

State	Enacted Reforms	Major Reform Proposals and Commission Studies
KANSAS Continued	*H.B. 2610 (1990)* Allows small businesses to establish health insurance purchasing groups. Also establishes administrative aid and tax incentives to encourage small businesses to provide insurance to their employees. *Kansas Healthy Kids* A school-based insurance program that provides medical services to children.	
KENTUCKY	*Kentucky Patient Access & Care (KenPAC) Program* A statewide program that pays primary care doctors an additional fee to serve as "gate-keepers" for their patients' care. Unlike some other Medicaid managed-care programs, this system does not require enrollees to join HMOs and does not make physicians share the risk of higher costs. *Kentucky Medicaid Access and Cost Containment Demonstration Project* A Medicaid expansion program, which in December, 1993, received a Medicaid waiver to extend program eligibility to those living at 100% of the poverty level and enroll recipients into the KenPAC program and other managed-care plans. *H.B. 250* A compromise plan the Governor and legislative leaders which establishes a Kentucky Health Policy Board to monitor the health care industry and enforce reforms. By July, 1995, insurers must guarantee issuance and renewal of their policies, charge enrollees a modified community rate, limit pre-existing condition exclusions, and limit physician self-referrals. In addition, H.B 250 establishes a state-wide health purchasing alliance by July, 1995, which will include state employees and possibly state Medicaid recipients. Individuals and businesses with fewer than 100 workers may join the alliance voluntarily.	NONE. Evolution of the reforms contained in H.B. 250 (see left) and the initiatives the Kentucky Health Policy Board set forth will comprise the state's major reform efforts.
LOUISIANA	*Louisiana Basic Health Insurance Plan (LA Health)* A managed-care basic benefit plan for low-income (those living at less than 250 percent of poverty) residents. No state funds are used for the program. *Louisiana Health Insurance Association* Offers affordable health coverage to residents who are deemed uninsurable because of their medical conditions. *Small Group Market Reforms* Guarantees policy issuance and renewal. Requires modified community rating, which prohibits insurers from varying the premium based on the health of small businesses' employees. Also limits new pre-existing condition requirements for enrollees moving from group to group.	*Senior Health Insurance Information Program (SHIIP)* Would train volunteers to provide insurance information, counseling and assistance to Medicare beneficiaries.

State	Enacted Reforms	Major Reform Proposals and Commission Studies
MAINE 	*Maine Small Group Access Law and Public Law 477* These two laws require insurers of small groups and individuals to guarantee policy issuance and renewal, and to practice modified community rating. Insurers must also offer two standardized plans to these groups. Claiming that these reforms will accommodate the state's uninsurable population, the state will eliminate its high-risk pool, phasing it out by January, 1995 *Public Law 867* Ensures portability of coverage by prohibiting insurers from instituting new pre-existing condition exclusions on persons moving from group to group.	*Maine Health Care Reform Commission* Established in 1994, the Commission is charged with developing three comprehensive health care reform models for implementation by July, 1997. One model must be a multi-payer system designed to provide universal coverage, another must be a single-payer universal coverage plan, and the third must be a model based on the current health care system that incorporates managed care and other mechanisms to control costs and improve access for uninsured state residents The 1996 Legislature will consider these plans.
MARYLAND 	*All-Payer Hospital Rate Setting System* Established in 1977, the All-Payer System determines each hospital's rates by the type and volume of services it provides to patients. It greatly reduces cost-shifting; hospitals receive nearly the identical rate for serving publicly and privately insured persons. Also, the rates the state's Cost Review Commission sets accommodate hospitals' budgets for uncompensated and charity care. *Maryland Access To Care (MAC) Program* Requires Medicaid recipients to select primary care physicians to oversee all of their care. Recipients are not placed in a managed-care organization; rather, physicians are paid individually through Medicaid funds to serve as "gatekeepers". *Public Law 93-9 (H.B. 1359)* Signed into law on April 13, 1993, the legislation enacts various insurance reforms. Requires insurers to offer standard benefit packages to small businesses with two to fifty workers. Insurers must guarantee policy issuance and renewal to small groups Phases out, by January, 1995, the use of pre-existing condition exclusions. Insurers must also use a phased- in, modified community rate for small groups, which may be expanded state-wide if certain "trigger mechanisms" are reached The legislation also establishes physician practice parameters, a data system to track costs, and stipulates that the Health Care Access and Cost Containment Commission develop, by January, 1995, a payment system for all practitioners in the state, similar to the All-Payer Hospital Rate Setting System currently in effect. The law also limits insurance company profits and the amounts that money brokers and agents can spend on administrative costs. Physician self-referrals are also banned *Maryland Kids Count Program* Offers a less extensive version of the standard Medicaid package to children ages one to 9.5 whose families earn up to 185 percent of the federal poverty level. The program offers preventive and primary care, but no hospital or emergency room coverage. 3Mental Health Care Reform (Public Law 94-2) Requires insurers in the state to provide mental health services comparable to the services they provide for other illnesses.	*Health Care Access and Cost Commission* The Commission is now working on several cost containment initiatives. These projects include: the development of a private-sector fee schedule for physicians, the establishment of a medical database, and the formation of practice parameters

State	Enacted Reforms	Major Reform Proposals and Commission Studies
MASSACHUSETTS	*The Health Security Act (HSA)* Enacted in 1988, the Act is a universal coverage plan based on the "play- or-pay" model. The play-or-pay strategy would require employers to either insure their workers or pay a tax to a state insurance program. Economic and political changes however, have caused the legislature to delay or reverse many main HSA provisions. For example, implementation of the "play or pay" requirement has been delayed until 1995, and may be repealed. Smaller reforms, however, have gone forward. The Legislature has implemented Health Security Plan (HSP), an insurance program tied to unemployment insurance and a requirement that all students attending college in the state have coverage. It has also enacted other programs, such as CommonHealth (a program for disabled children, disabled working adults and welfare recipients entering the workforce) and CenterCare (a primary health care program for low-income residents) but have been affected by budgetary constraints. *Small Group Market Reform* Enacted in December 1991, guarantees policy issuance and renewal, modified community rating and limits the use of pre-existing condition exclusions for small businesses (those with fewer than 25 employees). *Uncompensated Care Pool* Funded by surcharges to privately insured patients' bills, the pool subsidizes and distributes the cost of uncompensated care among hospitals in the state. *Healthy Kids Program* A state-subsidized health insurance plan for low-income, uninsured children from birth to age twelve.	*H.B. 4774* Governor William Weld's proposal for health care reform. The proposal would repeal the employer mandate included in the *1988 Health Security Act* (see left) and replace it with a system of tax credits, insurance market reforms and a Medicaid expansion for residents living under 133 percent of the federal poverty level. In addition, individuals could establish tax-exempt medical savings accounts for themselves, and low-income workers would be eligible for certain subsidies. *H.B. 2217* The Democratic proposal for health care reform. The proposal would preserve the *1988 Health Security Act's* (see left) employer mandate, scheduling it to go into effect in January, 1995. A Massachusetts Health Care Authority would oversee state health care reform. The Bill would establish health insurance purchasing pools and a health plan for low-income children. The legislation also includes community rating for small businesses. *Massachusetts Employment Support Program (ESP)* Governor Weld's program for welfare reform. Would replace the traditional cash grants to approximately half of the state's welfare recipients with support programs that enable them to go to work. Program enrollees in the program would receive extended Medicaid eligibility, day care and job training, but would be required to hold jobs or enroll in mandatory community service programs. The Governor filed a waiver with the federal government on March 16, 1994 to implement the program. The state legislature would also have to approve the plan.
MICHIGAN	*Medicaid Managed Care Plan* A voluntary program concentrated in urban areas that allows Medicaid recipients to choose from among managed care organizations. The organizations receive monthly fees to provide needed health care to recipients through primary care case management.	*The Michigan Health Access Program Act* A universal health care proposal based on a version of managed-care. The Act would set up six regional Health Insurance Purchasing Cooperatives (HIPCs) that would bargain with and certify health care plans. These plans, in turn, would provide a standard health care benefits package. The Act also establishes a State Health Commission responsible for implementing the Act and establishing global budgets for health care in each region. The Act did not pass last year and should not make much progress in 1994. *The Michigan Office of Health Care Reform and Policy Development* Formed by Governor John Engler in September, 1993. The office will work to improve quality and access to health care in the state while reducing overall costs. The Office is also charged with assessing the impact of federal reforms on the state.

State	Enacted Reforms	Major Reform Proposals and Commission Studies
MINNESOTA 	*MinnesotaCare Act of 1992* First part of an ongoing reform effort. Established the MinnesotaCare program for low-income residents who do not qualify for Medicare or Medicaid. Enacts the following small group market reforms: guaranteed policy issuance and renewal, modified community rating, limits on pre-existing conditions, and creation of a state-sponsored purchasing pool. Includes malpractice reforms, rural health and health education initiatives, and data collection and research initiatives. Also requires that the state Health Commission submit a plan to slow growth in health care spending and lays the foundation for later reform. *MinnesotaCare Act of 1993* Fills in some details of state's cost-containment strategy. Sets up large health care organizations known as Integrated Service Networks (ISNs) which the state will regulate to control costs. Provider participation in ISNs is voluntary, but providers that do not join will be subject to a more restrictive All-Payer System. There will be up to five standard ISN benefit plans, and officials anticipate that the networks will be similar to HMOs, but with budget caps. The state will regulate the ISNs and All-Payer System through growth limits and maximum cost enforcement to reduce health care spending growth by ten percent per year until it mirrors the Consumer Price Index. *MinnesotaCare Act of 1994* The third part of the state's MinnesotaCare Program, the Act delays implementation of ISNs and the All-Payer System, and also delays the enrollment of childless families into the MinnesotaCare program. The Act includes provisions for obtaining universal coverage in the state by 1997, but includes no funding sources. In addition, small, local provider organizations known as Community Integrated Service Networks (CISNs) are created and scheduled for operation in January, 1995. These CISNs cannot enroll more than 50,000 persons and are subject to HMO regulations. *The Minnesota Comprehensive Health Association (MCHA)* Established in 1976, this is the country's oldest and largest high-risk health insurance pool.	*Minnesota Long Term Care Commission* The Legislature established the Commission in August 1993 to develop a plan to cut Minnesota's long term care spending by ten percent over the next five years.
MISSISSIPPI 	*Public Law 94-302* Limits health insurance rate increases for small businesses and establishes requirements for coverage renewal. *Basic Benefit Plans* In 1992, the state enacted two laws creating voluntary "bare bone", low-cost benefit plans—one for low-income or uninsured individuals and one for small businesses. *State Comprehensive Health Association* The state's medical high-risk pool, provides health insurance to otherwise uninsurable residents.	*Governor's Commission On Health Care* Established by Governor Kirk Fordice, the Commission is responsible for studying the state's health care system and recommending many of the reform proposals the 1994 Legislature debated.

State	Enacted Reforms	Major Reform Proposals and Commission Studies
MISSOURI 	*H.B. 564* This incremental reform bill sets up a school-based health initiative to encourage school districts to provide primary care and Medicaid screening and treatment services to students. Authorizes "collaborative practice" agreements between doctors and nurse practitioners and physician assistants. Provides for state-funded liability insurance for health providers who provide free primary or preventive care. Creates incentives for physicians to practice in underserved areas. Expands Medicaid eligibility to pregnant women, infants, and children ages six to 18. Also sets up a Medicaid pilot program for 1,000 uninsured residents. *Small Group Market Reforms* Guarantees policy issuance and renewal for small groups, establishes rating restrictions to control premium variations between groups; and prohibits new pre-existing condition requirements for enrollees moving from group to group. *Medical High Risk Pool* Makes health coverage available for residents who do not qualify for insurance because of their medical conditions.	*Medicaid Reform Proposal* The state is in the process of drafting a Medicaid demonstration waiver request which would allow fundamental restructuring of the state's Medicaid program. The new program would place beneficiaries into managed care arrangements, which would enable the state to simplify and expand eligibility for the program. Low-income residents would also be allowed to buy into the program on a sliding scale.
MONTANA 	*Health Care For Montanans* A program of incremental reforms begun in 1990. Besides authorizing numerous studies, the program has also enacted a basic benefit plan and tax credit for small businesses, Medicaid expansions and managed care, maternal and child health initiatives, and tax credits and tuition rebates for physicians practicing in rural areas. *S.B. 285* In addition to creating the Montana Health Care Authority to design two universal access plans (see right), S.B. 285 includes small business insurance reform, such as guaranteed policy issuance and renewal, limits on pre-existing condition exclusions and modified community rating. Also includes a health care facility cooperative agreement act that will allow hospitals to work together for public benefit. *Medical High Risk Pool* Makes health coverage available for people who do not qualify for insurance because of their medical conditions.	*The Montana Health Care Authority* The Authority, which S.B. established, is charged with designing two universal access plans—one based on a single-payer system, and the other based on a regulated multi-payer plan. Both plans must include specific cost-containment provisions such as global budgeting for all health care spending in the state, an all-payer reimbursement system, and expenditure targets for providers and facilities. Each plan must also include a method for integrating federal programs such as Indian Health Services, VA, Medicare and Medicaid into the system. The Authority must submit both plans by October, 1994. The 1995 legislature will decide which plan to adopt, and implementation is scheduled to begin in October 1995.
NEBRASKA 	*Small Group Market Reforms (L.B. 1222)* Enacted in 1994, applies to businesses with 3–25 employees. Establishes two standardized benefit plans for small employers, limits the use of pre- existing condition exclusions, provides for coverage portability and establishes provisions for renewing health insurance coverage. The legislation also requires all insurers to use standardized claims forms and to provide immunizations for children under seven. *Comprehensive Health Insurance Pool* Makes health coverage available for people who do not qualify for other insurance because of their medical conditions.	*Interagency Health Care Advisory Committee* Governor Ben Nelson established this committee to lead planning for health care delivery in the state. *The Blue Ribbon Coalition* Also established by the Governor. The Coalition has drafted a proposal that would provide health coverage for all state residents.

State	Enacted Reforms	Major Reform Proposals and Commission Studies
NEVADA 	*A.B. 577 (1991)* An agreement negotiated with the state's six largest hospitals (which comprise 85 percent of the state's hospital billings), to control hospital costs by tying rate increases to the medical consumer price index. Agreement lasts through 1995.	*Nevada Health Care Committee* Has decided to approach the Health Care Financing Administration (HCFA) with two reform options for the state's Medicaid program. The state's goal is to implement a Medicaid managed–care program by July, 1995.
NEW HAMPSHIRE 	*Small Group/Individual Market Reforms (PL 94–294)* Enacts several insurance market reforms for individuals and small groups of fewer than 100. Insurers must practice modified community rating on these groups, differentiating pricing only by age. The use of pre–existing condition exclusions is limited and portability of coverage is guaranteed. *Medicaid Expansion (S.B. 77)* Expands Medicaid coverage to 185% of the federal poverty level for children 18 years old and younger *Public Law, Chapter 127* Requires insurance companies to accept standard insurance forms from health care providers in the state	*Medicaid Waiver Request* A 1994 law (PL Ch. 301) requires the state to seek a federal waiver to expand Medicaid coverage to adults between the ages of 18 and 64 whose income is under 50% of the federal poverty level.
NEW JERSEY 	*Health Care Reform Act of 1992* Ended the state's long–standing regulation of hospitals; allows them to set their own rates. Also began New Jersey SHIELD (see below), and instituted several small group and individual market insurance reforms (see below). *Small Group and Individual Market Reforms* Enacted along with the *Health Care Reform Act of 1992*, applies a play–or– pay model to insurers. Small market insurers must either offer five standard benefit packages on a guaranteed issue, community–rated basis to all groups that apply or pay an assessment to insurers that do. In addition, the legislation controls administrative costs, limits pre–existing condition exclusions; and regulates rate increases *New Jersey SHIELD* A state–subsidized, managed–care insurance plan for the state's uninsured. Beneficiaries pay premiums on a sliding scale and receive a standard benefit package, which emphasizes preventive and primary care.	NONE.
NEW MEXICO 	*1994 Reform Package* A package of ten bills, designed to improve the state's health care system; the Governor signed it in March 1994. Reforms include expansion of Medicaid eligibility to children living under 185 percent of poverty, requirements that insurers offer basic benefit plans, increased funds for emergency and rural health services, incentives for physicians to practice in underserved areas, and expansion of the state's health care data system. *Small Group Market Reforms* Guaranteed renewal and rating restrictions, which limit rate variance among plans from year to year. Low–cost, basic benefit plans are also available to small businesses and individuals.	*New Mexico Health Care Task Force* The state legislature established this commission in 1993, to design a plan that will achieve universal coverage in the state by October, 1997. The New Mexico Health Care Initiative (see below) and the state's Health Care Policy Commission will assist with the universal coverage project. *New Mexico Health Care Initiative* Established by a grant from the Robert Wood Johnson Foundation, Initiative members will assist the Task Force (above) in developing a universal coverage plan for the state

State	Enacted Reforms	Major Reform Proposals and Commission Studies
NEW MEXICO Continued	*Comprehensive Health Insurance Pool* The state's high-risk pool; makes coverage available to people who cannot afford insurance because of their medical conditions.	
NEW YORK	*New York Prospective Hospital Reimbursement* Methodology (NYPHRM) Established in 1983, this is the state's all-payer rate-setting system for hospital reimbursement. *Community Rating Law (A.B. 12350)* Went into effect April, 1993. Requires all insurers to guarantee policy issuance and renewal to all customers, regardless of age or health. Pre-existing condition exclusions are also limited. Also enacts one of the nation's strictest community rating laws—insurers cannot vary rates on the basis of a person's health, age or sex. *The New York State Partnership for Long Term Care* Part of a four-state demonstration project supported by the Robert Wood Johnson Foundation. Allows people to shield their assets from Medicaid "spend-down" requirements by buying private, state-approved, long term care insurance policies. *Medicaid Managed Care* A 1992 law requires that the state enroll half of its Medicaid recipients in managed-care organizations by 1998. *Child Health Plus* A state-wide program that subsidizes ambulatory, preventive and primary care for children younger than age 13 who are ineligible for Medicaid and have no other insurance.	*New York Health Care Advisory Board* The Board will issue a report to the Governor this fall. Topics under study include the establishment of Integrated Service Networks (ISNs), the state's role in national health care reform, and three financing structures (single-payer, market-based, and a hybrid of ISNs and a regulated system). In addition, the Governor is expected to introduce a health reform package during the year-long legislative session. Republican leaders will likely follow the Governor's lead.
NORTH CAROLINA	*Health Care Reform Act of 1993* Ratified on July 23, 1993, allows small businesses (those with three to 49 employees) to combine into purchasing cooperatives. Calls for standardized insurance forms and creates a study commission to develop a plan for universal health coverage. Also amends antitrust laws, to allow hospitals to cooperate, and requires state-funded medical schools to develop plans for training more primary care physicians. *Small Group Market Reforms* Small market insurers must guarantee policy issuance and renewal. In addition, rating restrictions to control premium variations between groups are required, and new pre-existing condition exclusions against previously insured individuals are prohibited.	*North Carolina Health Planning Commission* Established under the *Health Care Reform Act of 1993*, the Commission is charged with developing a comprehensive health care reform plan for introduction to the 1995 legislature.
NORTH DAKOTA	*Small Group Market Reforms* Small market insurers must guarantee policy issuance and renewal. In addition, rating restrictions to control premium variations between groups and new pre-existing condition exclusions against previously insured individuals are prohibited. *Medical High Risk Pool* Offers health care coverage to residents who, because of their medical conditions or histories, find market-based insurance unaffordable.	*North Dakota Health Task Force* The Task Force recently released two universal health care proposals for the state: a private single-payer plan and an employer-based plan. Although they utilize different financing, each plan allows residents who receive care from federal programs, such as Medicaid, VA or CHAMPUS, to opt out of the state system and continue to receive care through the federal government. The Task Force has scheduled public meetings to receive comment on the proposals before it meets again.

State	Enacted Reforms	Major Reform Proposals and Commission Studies
OHIO 	*H.B. 478* Reforms various aspects of the health care market. In the small employer market, the bill guarantees policy issuance and renewal, limits pre-existing condition exclusions, allows small businesses to band together into small employer health alliances to negotiate for insurance. Allows self-employed to deduct 100 percent of health care costs from their state income taxes. Mandates that insurers accept a certain percentage of high-risk residents during open enrollment periods. Extends Medicaid benefits to uninsured children under 200 percent of poverty. Also creates the Ohio Health Care Board, a permanent policy-setting entity, which will develop a universal access plan.	*OhioCare* A Medicaid expansion program which would extend enrollment eligibility to all residents living under the federal poverty line. Financing would come from savings achieved by enrolling the state's Medicaid population into managed care plans. An estimated 500,000 persons would join 1.4 million beneficiaries already in the state's Medicaid program. A Medicaid waiver request was sent to the Health Care Financing Administration on March 2, 1994 to implement the program.
OKLAHOMA 	*Oklahoma Health Care Authority (OHCA) Act* Creates the OHCA and transfers state health care spending (Medicaid and employee health benefits) to it. The Authority is also charged with examining ways to reduce these programs' costs and direct the conversion of the state's Medicaid population into managed-care plans. *Small Group Market Reforms* Guarantees policy renewal for groups, provides rating restrictions to control premium variations between groups and prohibits new pre-existing exclusions requirements for enrollees moving from group to group. *H.B. 2256* Enacted May 1994, requires insurers to issue medical coverage to all workers in businesses employing fewer than 100 people, regardless of health risks or condition. *Health Insurance Opportunities for Employed Uninsured Oklahomans Act* Provides tax incentives to encourage employers to offer workers a basic health benefit package.	NONE.
OREGON 	*The Oregon Health Plan* Enacted in 1989, is a package of three bills that overhauls the Oregon health care system. Includes the controversial "rationing experiment", which extends Medicaid coverage to 100 percent of the poverty level, while limiting services covered to the 565 "condition/treatment pairs" ranked highest among 696. Includes a play-or-pay provision that mandates all employers to either provide basic coverage to their employees or pay into a state insurance pool on their behalf. Large businesses must comply with the mandate by April, 1997, while small businesses must comply by January, 1998. The employer mandate may be repealed altogether however, if the state cannot obtain an ERISA waiver from the federal government by January 1996. A medical high-risk pool for the state's uninsurable residents was also established. In March 1993 the state received federal which allow implementation of the Medicaid reform program for a period of five years, beginning in February 1994. *Small Group Market Reform (S.B. 1076)* Requires insurers to guarantee issuance and renewal of two basic benefit plans to small groups. Requires modified community rat	NONE The state will attempt to obtain a federal ERISA waiver by January 1, 1995, to implement the employer mandate.

State	Enacted Reforms	Major Reform Proposals and Commission Studies
OREGON Continued	ing for the basic benefit plans and limits pre–existing condition exclusions *Medical High Risk Pool (S.B. 534)* Makes health coverage available for residents who do not quality for other insurance because of their medical conditions.	
PENNSYLVANIA	*Children's Health Insurance Program (CHIP)* A comprehensive health plan that provides free or low–cost health care for children under age 14 living at or under 235 percent of the federal poverty level. Funded by a cigarette tax.	*The Pennsylvania Health Security Act* Would provide universal coverage through an employer mandate and a subsidized state–run plan for low–income uninsured persons living at or under 250 percent of the federal poverty level. Small businesses would qualify for assistance and their premiums would be limited to 7 percent of their payroll. While subsidies would be tied to the lowest priced plan, individuals could pay additional premiums for expanded services. Would deliver care through provider networks competing within health service regions under the oversight of a nonprofit public board. The board would also design a guaranteed benefit package, designate health service regions and identify funding sources and uses. Other components of the Act include malpractice reform, limits on self–referrals, and incentives for physicians to practice in medically underserved areas.
PUERTO RICO	*Universal Health Care System* Currently all residents are provided health care services through a two–tiered system of public and private insurance. Residents who can afford private insurance receive care from state–of–the–art private hospitals and clinics. The indigent majority receive health care though a system of hospitals and clinics run by the state and municipal governments. To serve the medically indigent population, the island is divided into seven geographic public health zones, each with one or two hospitals and several clinics. *Puerto Rico Health Insurance Administration Act (Act 72)* Approved in September, 1993, the Act is part of Governor Pedro Rossello's reform plan to privatize Puerto Rico's vast public health system. The Act creates the Puerto Rico Health Insurance Administration (PRHIA), an autonomous public corporation which is responsible for pooling residents together and contracting with private, managed care organizations to provide health care services. These managed care organizations must accept everyone who applies, cannot restrict coverage because of pre–existing conditions, and must provide a basic benefit package. Government subsidies are provided to low–income residents. Before implementing the reform system island–wide, the PRHIA has established a pilot program to test the system in one of its seven public heath zones.	*Puerto Rico Health Task Force* Established in early 1993, the Task Force is responsible for forwarding the Governor's plans to privatize Puerto Rico's large public health system. The Governor's goal is to change the Commonwealth's role from health care provider to health care purchaser by contracting with private insurers to deliver health care to the medically indigent.

State	Enacted Reforms	Major Reform Proposals and Commission Studies
RHODE ISLAND 	*Rite Care Program* The program received a federal Medicaid waiver in November, 1993, for a five-year demonstration period, to begin in July 1994. Funnels 65,000 current Aid to Family and Dependent Children (AFDC) Medicaid recipients and another 10,000 formerly uninsured, pregnant women and children under age six into managed-care plans. If the project is successful, the state may enroll its entire Medicaid population into managed care. *Small Group Market Reforms* Guarantees policy issuance and renewal for groups, provides rating restrictions to control premium variations between groups, and prohibits new pre-existing condition requirements for enrollees moving from group to group.	NONE
SOUTH CAROLINA 	*South Carolina Health Access Plan* One of three federal funded pilot programs operational in two counties. Offers low-income employees of small businesses Medicaid-based managed-care insurance for themselves and their dependents. If successful, the program could expand to other areas or throughout the state. *Small Employer Health Insurance Availability Act* Allows small employers to group together to form purchasing cooperatives to bargain for lower health insurance premiums. The Act also requires insurers to cover any small business that applies, charge premiums on a modified community rate, and limit the use of pre-existing condition exclusions. In addition, insurers must offer small groups at least the two standardized benefit plans included in the Act. *Medical High Risk Pool* Makes health coverage available for residents who do not qualify for insurance because of their medical conditions.	*The Palmetto Health Initiative* This program would expand the state's Medicaid program to 100 percent of the federal poverty level for all residents and to 133 percent of the poverty level for all children. Current Medicaid beneficiaries and the newly eligible would be placed into managed-care arrangements and receive comprehensive medical care. The state submitted a federal Medicaid waiver proposal to the Health Care Financing Administration on March 3, 1994, to implement the program. *Committee on Health Reform* Enacted under the *Small Employer Insurance Availability Act* (see left), is responsible for issuing health care reform recommendations by January 1995. Specifically, the Commission will be studying the possibility of creating medical savings accounts, accountable health plans, voluntary insurance purchasing cooperatives and rating methodologies.
SOUTH DAKOTA 	*Small Group Market Reforms (S.B. 229)* Establishes rating restrictions to control premium variations between small businesses. Also requires insurers to guarantee policy renewal. *1994 Reform Package* Consists of numerous bills aimed at improving health care delivery in the state. Reforms include the establishment of a health data system, limits on pre-existing condition exclusions and physician self-referrals, permission for individuals and groups to form purchasing pools, requiring physicians to post their fees, the establishment of South Dakota Health Care Authority and the South Dakota Advisory Council, and the development of standardized claims forms. *Medical High-Risk Pool* Scheduled to begin operation on July 1, 1995; will offer affordable health insurance to residents who cannot afford coverage because of their medical status.	*South Dakota Advisory Council* Expanded and redefined under the 1994 reforms, the Council will studying long term care, coverage of uninsurable residents, and rural health care problems. The Council will also monitor national health care reform plans. *South Dakota Health Care Authority* Established in 1994, the Authority is charged with analyzing the current health care system and its problems, developing a health benefit plan for legislative approval, and developing a comprehensive universal health care plan for the state.

State	Enacted Reforms	Major Reform Proposals and Commission Studies
SOUTH DAKOTA Continued	*Rural Health Initiatives* Includes special appropriations to improve rural emergency, medical and communication services, eased licensure requirements and a program that allows counties to guarantee bonds issued to private, nonprofit hospitals to raise money for facility improvement and equipment purchase.	
TENNESSEE	*TennCare* A statewide Medicaid managed–care program. Places current Medicaid recipients and approximately 500,000 uninsured residents into managed– care organizations, which are contracted to provide comprehensive medical benefits. Free care is provided to residents living under the federal poverty line. Residents earning up to 400 percent of the federal poverty level pay premiums on a sliding scale, and residents earning more than 400 percent of poverty may buy into the program, paying full price. The program was granted a federal Medicaid waiver from the Health Care Financing Administration to implement the program on November 18, 1993. TennCare began enrolling residents on January 1, 1994. *Small Group Market Reforms* Guarantees policy issuance and renewal for groups, establishes rating restrictions to control premium variations between groups, and prohibits new pre–existing condition exclusions for enrollees moving from group to group. Insurance companies must also offer basic and standard benefit plans to all small business employees. *The Health Access Incentive Program* A program designed to attract primary care physicians to medically underserved areas. Offers loan repayments and start–up grants as incentives. *The Tennessee Comprehensive Health Insurance Pool* Makes health coverage available for residents who do not qualify for insurance because of their medical conditions.	NONE.
TEXAS	*Small Employer Health Insurance Availability Act* Enacted in June, 1993, to make health insurance more accessible and affordable to small employers (those with three to 50 workers). Creates the Texas Health Benefits Purchasing Cooperative to give small employers more purchasing power. Also allows for the creation of private, nonprofit purchasing cooperatives. Requires all small group insurers to offer three small employer benefit plans. Requires guaranteed policy issuance and renewal by September 1995, establishes modified community rating, restricts pre–existing condition exclusions and creates a re–insurance pool for insurers of small employers. *Child Health Initiatives* Expands existing school–based health services and guarantees immunization for all children in the state. *The Texas Health Insurance Risk Pool* Created in 1989 to provide medically uninsurable individuals the opportunity to purchase adequate health insurance at a reasonable rate.	NONE. No legislative session is scheduled for 1994. The Legislature will reconvene in January, 1995.

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State	Enacted Reforms	Major Reform Proposals and Commission Studies
UTAH 	*H.B. 130* A 1993 incremental reform bill, which includes grants to expand primary care in medically underserved areas, a requirement that insurers facilitate price and value comparisons for their policies, establishment of standard claims and billing forms, and other, smaller reforms. *S.B. 158 (1994)* Includes a phased-in Medicaid expansion, which will eventually cover all residents living under the federal poverty line. Small group market reforms prevent abusive rating practices and require insurers to cover dependents up to age 26. *Comprehensive Health Insurance Pool Act* Signed into law in May, 1990; created a medical high-risk pool, which provides health insurance to state residents considered uninsurable.	*Utah Health Policy Commission* Created by a 1994 bill (H.B. 226), the Commission is charged with recommending future reforms to the legislature. The Commission will also seek to further the initiatives in the Governor's Healthprint plan (see below). *Utah Healthprint* A market-oriented health care reform plan the Governor released early this year. The plan calls for phased-in Medicaid expansions and insurance reforms, such as modified community rating, guaranteed policy issuance and renewal and limitations on pre-existing condition exclusions. The insurance reforms focus first on the small group market and may later apply system-wide. Also includes a purchasing cooperative for individuals and small employers.
VERMONT 	*The Vermont Health Care Act of 1992 (Act 160)* A reform initiative originally designed to achieve universal access in Vermont by July, 1995. Created the Vermont Health Care Authority (VHCA) which was charged with designing two models for universal coverage to be voted on by the 1994 Legislature. Neither plan passed the Legislature, effectively ending the state's three year push for universal coverage. However, the Act includes other, smaller reform initiatives, such as the establishment of a purchasing pool for local and state employees, individual market reforms, and the establishment of a unified health care data base and universal billing forms. *Small Group Market Reform (Act 52)* Guarantees policy issuance for small groups with fewer than 50 participants, establishes modified community rating (health status cannot be considered), limits pre-existing condition exclusions, and requires insurers in the small group market to offer standardized benefit plans. The 1992 Act (see above) extends these restrictions to the individual market.	NONE Although the state spent three years pursuing enactment of a universal health coverage plan, in the end, the 1994 state legislature failed to pass any comprehensive reform measures.
VIRGINIA 	*The Dr. Dynasaur Program* Expanded by the 1992 Act, provides health coverage to low- and moderate- income (living below 225 percent of poverty) children up to age 18 and pregnant women who do not qualify for Medicaid *Virginia Health Care Foundation* A public/private endowment, which funds community-based projects designed to improve primary care access in medically underserved areas.	*Joint Commission on Health Care* An ongoing committee charged with studying managed competition, the American Hospital Associations' plan for community care networks, and other reform plans.
WASHINGTON 	*Small Employer Reforms* Insurers who provide coverage to small employers must offer "essential and standard" health plans at a modified community rate. Guarantees policy issuance and renewal and limits pre-existing condition exclusions. *The Washington Basic Health Plan* A state-subsidized health care program for the state's	The continued development of the *Washington Health Services Act* will comprise most of the state's reform activity. Of interest will be the state's plans to consolidate federal programs such as VA and CHAMPUS under the Consolidated State Purchasing Agent (see left).

State	Enacted Reforms	Major Reform Proposals and Commission Studies
WASHINGTON Continued	low–income uninsured. Offers a basic benefit plan to its enrollees, who pay premiums on a sliding scale. *The Washington Health Services Act of 1993* A universal reform plan that requires all residents to have access to a Uniform Benefits Package (UBP) by 1999. Includes a phased–in employer mandate, which requires all businesses to pay for a percentage of the Uniform Benefits Package for their full– and part–time workers. Small businesses and low–income workers will be eligible for state assistance, and an expansion of the state's Basic Health Plan and Medicaid will cover the unemployed. Four regional Health Insurance Purchasing Cooperatives (HIPCs) are created for those who will purchase insurance and a Consolidated State Purchasing Agent (CSPA) is created for those residents who receive their coverage from the state. If the state can obtain the proper waivers, it would like to include federal programs such as Medicare, Medicaid, CHAMPUS and VA in the CSPA. These purchasing pools will then contract with Certified Health Plans (CHPs) to deliver the Uniform Benefits Package on a guaranteed issue, community rated basis. In addition, the Act establishes a premium cap for the Uniform Benefits Package and guarantees policy renewal. To control health care costs in the state, the growth rate of the Uniform Benefit Package's premium cap will be reduced by two percent per year until it equals the growth rate in Washington's per capita income.	
WEST VIRGINIA	*High Risk Health Pool* Provides access to health services for residents whose medical conditions prohibit them from purchasing other insurance coverage at an affordable cost. *1994 Medicaid Expansion (H.B. 5008)* Expands Medicaid coverage to children (ages two to 18) living in families earning up to 150 percent of the federal poverty level. The children's expansion will be phased in over three years, beginning in 1994. In addition, the legislation extends optional Medicaid benefits to hospice patients qualifying for the program.	NONE. Although Governor Caperton pushed hard for his 1994 reform package (S.B. 54/H.B. 4054), disagreements in the legislature and provider groups lobbying combined to defeat the bill. Included in the legislation was the Governor's second attempt at establishing an administratively powerful West Virginia Health Care Authority, which would have been responsible for coordinating state health programs and implementing reforms.
WISCONSIN	*Small Group Market Reforms* Guarantees renewal for small businesses and provides rating restrictions to control premium variations between groups. Also expands the definition of small businesses to include groups of up to 75 people. *Health Insurance Risk Sharing Plan* The state's high–risk pool; provides major medical health insurance to certain high–risk individuals unable to obtain private insurance coverage. *Small Group Market Reforms* Guarantees policy issuance and renewal for groups; Establishes rating restrictions to control premium variation between groups; and prohibits new pre–existing condition requirements for enrollees moving from group to group. Also approves the creation of basic benefit plans at lower cost for small employers.	NONE. Although several proposals were put forward, the 1994 Legislature adjourned without passing any comprehensive health reform measures.

State	Enacted Reforms	Major Reform Proposals and Commission Studies
WISCONSIN Continued	*Healthy Start Program* Provides low-income children between the ages of 2 and 6 with comprehensive Medicaid-like health coverage.	
WYOMING	*The Wyoming Health Insurance Pool* Makes insurance coverage available for residents who do not qualify for other insurance because of their medical conditions. *Small Group Market Reforms* Guarantees policy issuance and renewal for groups, establishes rating restrictions to control premium variations between groups, and prohibits new pre-existing condition exclusions for enrollees moving from group to group.	*Wyoming Health Reform Commission* Established by Governor Mike Sullivan; is scheduled to submit a state-wide health care plan to Governor Sullivan by December 1, 1994

State Reforms That Could Affect the VA Health Care System

States are proposing a variety of reforms that are likely to have consequences—both positive and negative—for the VA health care system. Many reforms being considered, proposed, and implemented at the state level are discussed below. The probable impacts of these reforms on the VA medical system are also discussed. VA's role must be considered and addressed, for, as can be seen below, any type of health care reform can impact the nation's largest health care system, thus jeopardizing our nation's commitment to veterans.

Universal Coverage

States Implementing This Reform:
Hawaii, Oregon, Massachusetts, Washington

States Considering This Reform:
California, Maine, Minnesota, Montana, North Dakota, Pennsylvania, South Dakota

Impact:
Affects Health Care Coverage. Threatens to erode VA's patient base as VA eligible residents have more opportunities to receive health care. To integrate VA with the local health care environment, state reforms need to specify VA's role. VA system structural changes are also needed for it to compete on a level playing field for patients.

Single-Payer Financing Systems

States Implementing These Reforms:
None

States Considering These Reforms:
California, Maine, Montana, North Dakota

Impact:
Affects All Providers and Payers by Standardizing Benefits and Making Coverage Universal. Single-payer financing would threaten VA's patient base, as individuals could choose their provider. State and federal reform legislation is needed for VA to fully participate in a single-payer health care system.

Health Insurance Purchasing Pools/Managed Competition Plans

States Implementing These Reforms:
California, Florida, Iowa, Kentucky, Minnesota, North Carolina, Ohio, Texas, Washington

States Considering These Reforms:
Arizona, California, Connecticut, Kansas, Massachusetts, Michigan, New Hampshire, Utah

Impact:
Affects Health Care Coverage. These devices offer more opportunities for individuals to receive reasonably priced private insurance. VA may face patient base attrition unless it is allowed to become a state-certified health plan and compete for insurance pool members.

Employer Mandates

States Implementing These Reforms:
Hawaii, Massachusetts, Oregon, Washington

States Considering These Reforms:
North Dakota, Pennsylvania

Impact:
Affects Health Care Coverage for Employed Individuals. Employer mandates increase opportunities for persons to obtain private insurance. But these mandates may also decrease the VA patient base unless VA can attract patients with a comprehensive health benefit plan equal to private plans.

Medicaid Reforms

- Changes in Benefits Package
- Waivers from Health Care Financing Administration (HCFA) to Expand Coverage

States Implementing These Reforms:
Arizona, California, Hawaii, Kentucky, Maryland, Michigan, Minnesota, Missouri, Montana, New Mexico, New York, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Washington, West Virginia

States Considering These Reforms:
Alabama, Florida, Illinois, Massachusetts, Missouri, Montana, Nevada, New Hampshire, North Dakota, Ohio, South Carolina, Utah

Impact:
Affects Availability or Coverage of Health Care and Possibly Benefits. Again, any expansion of coverage provides individuals with more opportunities for coverage and provides more competition for VA. Medicaid expansions and reforms are of concern, because these reforms target a population, including veterans, who disproportionately use VA: the low-income and disabled. Some Medicaid packages are more comprehensive than those currently available to many veterans using VA, so Medicaid may be a more attractive health care coverage. Some states have intentionally excluded veteran users of VA, because of confusion over eligibility and the benefits available to veterans in VA. Reforms must allow veterans to participate in any state program for which, as state residents, they are otherwise eligible.

At the same time, by failing to consider VA in these reforms, states not only endanger VA, but may also lose opportunities to shift costs for veteran residents to the Federal government. To compete effectively with private health plans, VA must have state and local support.

Creation of Standard Benefit Packages

- Standardized benefit packages for state health reform plans and insurance purchasing pools
- "Bare Bones" benefit packages

States Implementing These Reforms:
Alabama, Alaska, Arizona, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Montana, Nebraska, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Tennessee, Texas, Vermont, Virginia, Washington, Wisconsin

States Considering These Reforms:
Maine, Michigan, Nevada, New Hampshire, North Dakota, South Dakota, Utah

Impact:
Affects Benefits Availability. Standard benefit plans' effect on VA would depend on the benefits included. Comprehensive benefit plans that include primary care, dental care, and other services not widely available through VA, may draw patients

from VA. Standardized benefit plans that offer only basic services, however—which is often the case—would not be as likely to effect VA's patient base, as individuals would continue to use VA for specialized, rehabilitative, or long term care

Insurance Market Reforms

- Guaranteed Issue Limitations on Exclusions for Pre-existing Conditions
- Requirements for Reinsurance—Portability, Renewability
- Requirements for Community Rating Controlling Variation in Premium Variation

States Implementing These Reforms:
All but Michigan, Nevada, Pennsylvania

States Considering These Reforms:
Pennsylvania

Impact:
Affects Health Care Coverage Insurance market reform is likely to draw higher-risk patients from VA. Such reforms aim to make coverage less discriminatory and provide more financial access to care

Creation of Medical High-Risk Pools

States Implementing These Reforms:
Alaska, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, New Mexico, North Dakota, Ohio, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, Wisconsin, Wyoming

States Considering These Reforms:
Idaho

Impact:
Affects Health Care Coverage. Provides a "safety net" to individuals who cannot obtain insurance through traditional avenues. May increase access for some individuals, especially disabled persons, some of whom may receive VA care These individuals may then choose private coverage other than VA health care.

Special State Initiatives to Incorporate VA Medical Care Facilities into Health Care Reform Plans

Status:
Of the countless reform initiatives the 50 states have undertaken, only four states' reform legislation even mentions VA. These four states—Minnesota, Montana, North Dakota, and Washington—have either included VA for further study or assigned it a secondary role under their proposed reforms. Although a VA role has not been defined in the legislation of Florida and Minnesota, both states have been working with VA leadership to include VA in their plans However, no state has yet made VA integral to their reform plans.

Minnesota:
Included in the recently enacted 1994 MinnesotaCare legislation is a provision which allows any department, agency, or instrumentality of the federal government to organize an Integrated Service Network (see Minnesota section) under the state's reform plan. Specifically, this will allow VA to establish an ISN that will be able to serve veterans exclusively. There is also language in the Act requiring the Commissioner of Health to recognize the unique problems of veterans and to consider methods to reach underserved portions of the veteran population in developing and implementing initiatives to expand access to health care.

Montana:
Montana has stated VA its Health Care Authority to study VA and other federal health care programs, such as Indian Health Service, Medicare and Medicaid. A 1993 reform bill, S.B. 285, charged the Authority with designing two universal health care access systems. Each of these plans must include a method of integrating federal programs into the overall system. The Authority has not yet determined exactly how to include the programs in their reform proposals

North Dakota:
When the North Dakota Health Task Force released its recommendations for state health care reform, it established a role, although a secondary role at best, for VA. Under each of the two Task Force's reform proposals VA care (along with CHAMPUS and Medicaid) would remain an option for residents. Residents choosing these services would have to specifically opt out of the state's reform program to seek services from federal programs.

Washington:
Like Montana, Washington State has also charged a committee with studying means to integrate VA and other federal health care into its reform plan. The state's universal coverage plan includes a purchasing pool for residents who receive state coverage known as the Consolidated State Purchasing Agent (CSPA). The state seeks to consolidate veteran programs and CHAMPUS (along with Medicare and Medicaid, provided federal waivers are granted) into the Consolidated State Purchasing Agent. The state's Legislative Budget Committee is responsible for designing the best method to accomplish this integration. Whether VA becomes a state-certified health plan or a contracted provider has not been determined

Florida:
Although the state's enacted legislation has failed to specify a role for VA, the state has worked with VA officials in considering future reform. Legislation in this year's Florida legislature would have allowed VA to become an "Accountable Health Partnership" able to provide medical care to eligible residents enrolled in Florida's Community Health Purchasing Alliances (CHPAs). However, the legislation did not pass during this year's regular session.

Key Elements of Successful VA integration into State Health Care Reform Plans

For the VA health care system to successfully survive in this new era of health care reform many changes must be undertaken, not only by VA itself, but by state and federal legislators as well. Thus far, states have been slow to consider VA's role in their health care reforms. However, there is much that states and VA can, and need, to do. Below are PVA's recommendations to ensure a strong future existence for the VA medical system.

Under Any Type Of Health Care Reform, PVA Recommends:

- VA medical facilities should become active in their communities' health care networks

- VA providers should optimize opportunities to decentralize, specialize and share services with external partners.

- No state health care reform should prohibit veterans receiving care in VA hospitals from participating in any program for which they, as state residents, are otherwise eligible. Some state reform plans allow eligible residents to enroll in programs with more comprehensive benefits (particularly primary and preventive care) than many veterans can currently receive in VA. Some states have attempted to exclude veterans from their state program, which may deprive this class of citizen of benefits available to other residents.

Under State Reform, PVA Recommends:

- VA medical centers should seek legislative relief to allow themselves to conform to state standards and become certified providers (for example, members of purchasing groups).

- Should a state define a basic benefits package qualified providers will deliver to state residents, VA medical centers within the state should be able to provide the same benefits to its patients. PVA has traditionally supported making the full range of VA services available to all core group veterans (service-connected, low-income or special category) veterans. PVA has also advocated designating catastrophically disabled veterans as core group veterans.

- VA should be allowed to make primary care accessible to all of its users. If VA medical centers cannot provide this care themselves, they should seek partnerships with DOD or academic affiliates or contract for the care through private-sector providers.

- Under reform, all veterans (including non-core group veterans) and veterans' dependents should be permitted to use VA. Non-core group veterans or dependents must support the cost of their care, either on their own or through a third-party payer. Congress should allow these dollars (outside of appropriations) to remain in VA. If space and resources are limited, the following priorities should apply to enrollment: 1. Core group veterans (including the catastrophically disabled); 2. other veterans; 3. veterans' dependents. VA should seek to provide care, either as the direct provider or as the payer, to as many of these individuals as possible.

- A non-state resident now receiving care from a VA facility should not be prohibited from using the VA medical center he or she considers (and can demonstrate) to be his or her main source of health care.

- Under significant reform, states should join VA in advocating that VA medical centers receive additional funding for marketing and customer service.

- VA medical centers in states actively pursuing health care reform should seek legislative freedom from restrictive staff floors and ceilings. These prohibit centers from using staff and resources cost-effectively and efficiently.

- PVA supports a Congressional proposal H.R. 4013 described in the last section of this publication, "U.S. House and Senate VA/State Health Care Reform Legislation". H.R. 4013 and a similar Senate proposal (S. 1974) would award grants to selected states that are implementing reform to establish pilot programs. Pilot programs would allow these states' VA providers more flexibility to participate in their states' reformed system. PVA recommends that states enacting comprehensive health care reform seek such grants.

- VA medical center directors must continue to maintain the integrity of their specialized services. Such programs, including spinal cord injury, blind rehabilitation, psychiatric care, and other "chronic care" services will be critical in a new health care environment that emphasizes primary care.

- Reform should allow VA to establish revolving funds in which they may keep reimbursements that accrue from funding streams outside Congressional appropriations for VA.

- VA should maintain a system that is dedicated to the health care of veterans, but should simultaneously maxi-

State Reforms That Could Affect Programs for Disabled Populations

States are proposing a variety of reforms which are likely to have consequences—both positive and negative—for disabled populations. Many of the reforms being considered, proposed, and implemented at the state level are discussed below. The probable impacts of these reforms on disabled populations in the aggregate are also discussed. However, some reforms will have different impacts on one state's disabled population than on another's. For example, the introduction of a basic benefits package which extends "bare bones" coverage to populations with no coverage may have a positive impact for some individuals (including some disabled people), but may negatively affect individuals already entitled to a fairly comprehensive range of services. This "breadth for depth" dilemma is at the heart of the quest for comprehensive coverage for all populations.

Universal Coverage

States Implementing This Reform:
Hawaii, Massachusetts, Oregon, Washington

States Considering This Reform:
California, Maine, Minnesota, Missouri, Montana, North Dakota, Pennsylvania, South Dakota, Vermont

Impact:
Affects coverage for health care. Likely to positively affect disabled persons because coverage will be available for all without excluding those with pre-existing conditions or otherwise discriminating on the basis of health status.

Single Payer Financing Systems

States Implementing These Reforms:
None.

States Considering These Reforms:
California, Maine, Missouri, Montana, North Dakota, Vermont

Impact:
Affects all providers and payers by standardizing benefits and making coverage universal. Seriously disabled persons would likely benefit from the guaranteed coverage (without pre-existing condition limitations) implicit in a single-payer system. Disability advocates must scrutinize the benefits package covered under such a system to ensure that it can deliver adequate health care to disabled people without excessive out-of-pocket costs.

Health Insurance Purchasing Pools/Managed Competition Plans

States Implementing These Reforms:
California, Florida, Iowa, Kentucky, Minnesota, North Carolina, Ohio, Texas, Washington

States Considering These Reforms:
Arizona, California, Connecticut, Kansas, Massachusetts, Michigan, Missouri, New Hampshire, Oklahoma, Utah

Impact:
Affects Health Care Coverage. May offer disabled individuals more opportunities to receive private insurance. Purchasing pools may allow employers of disabled people lower premiums, because these employers share risk with other insurance purchasers.

Employer Mandates

States Implementing These Reforms:
Hawaii, Massachusetts, Oregon, Washington

States Considering These Reforms:
North Dakota, Pennsylvania, Vermont

Impact:
Affects Health Care Coverage for Employed Individuals. With community rating, mandates are likely to be somewhat effective. Without community rating, employers may discriminate in hiring, to avoid paying higher premiums to insure disabled employees. Guaranteed coverage through employers for a fairly comprehensive benefits package would also benefit disabled individuals by removing a significant disincentive to work. Disabled individuals, should they become employed, risk their public assistance for health care benefits. This loss is significant, given the costs of durable medical equipment and other services disabled individuals require.

Medicaid Reforms

- Managed Care
- Changes in Benefits Package
- Waivers from Health Care Financing Administration (HCFA) to Expand Coverage

States Implementing These Reforms:
Arizona, California, Hawaii, Kentucky, Maryland, Michigan, Minnesota, Missouri, Montana, New Mexico, New York, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Washington, West Virginia

States Considering These Reforms:
Alabama, Florida, Illinois, Massachusetts, Missouri, Montana, Nevada, New Hampshire, North Dakota, Ohio, Oklahoma, South Carolina, Utah

Impact:
Affects health care availability and coverage and, possibly, benefits. The Federal government and the states fund Medicaid. The Federal government, through the Health Care Financing Administration (HCFA) sets standards states must meet to obtain federal funding. These standards include a minimum standard benefits package and guaranteed enrollment for specified categories of individuals—blind people, disabled individuals, and elderly individuals and Aid to Families with Dependent Children beneficiaries. States may exceed the minimum benefits standards and receive "matched" funds. The breadth of states' benefits packages varies significantly. Some states are now asking HCFA to exempt them (under "1115" Medicaid waivers) from some of their requirements so that they may use federal funding to expand coverage for residents. This may not benefit disabled populations who are often already eligible for coverage. In fact, it could, in some instances, be detrimental, because to finance reform, states may cut services disabled popula-

tions typically use. On the positive side, however, higher-income disabled people (including some uninsured and uninsurable) may have new-found access to more comprehensive "Medicaid-like" benefits packages.

The effect of placing more of the Medicaid disabled population in managed care programs is unknown. Managed care will likely enhance access to preventive and primary care services, but may block established relationships with specialists trained to deal with disabled peoples' needs.

Creation of Standard Benefit Packages

- Standardized benefit packages for state health reform plans and insurance purchasing pools
- "Bare Bones" packages

States Implementing These Reforms:
Alabama, Alaska, Arizona, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Montana, Nebraska, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Tennessee, Texas, Vermont, Virginia, Washington, Wisconsin

States Considering These Reforms:
Maine, Michigan, Nevada, New Hampshire, North Dakota, South Dakota, Utah

Impact:
Affects benefits availability. Advocates of disabled people should look for standard package features that enhance chronically disabled peoples' independence and quality of life. Such features might include expanded access to long-term care programs (such as nursing home, adult day health, respite, hospital-based home care, community residential care, and personal assistance) in institutions, communities, and homes; durable medical equipment; medical supplies; short- and long-term rehabilitative programs; and, prosthetics. These services are not typically available in standard benefits packages.

To provide some individuals with minimal insurance coverage, some states are standardizing benefits packages available to lower-income individuals. These packages are sometimes available with subsidization. Packages may include minimum benefits package that may adequately cover healthy individuals with "main-stream" health care needs. Some packages only protect individuals from catastrophic care costs (that is, they may limit out-of-pocket expenditures to $10,000). While such policies may extend minimal care (particularly preventive and primary care) to residents who currently have none, they are not likely to address disabled populations' needs. Disabled populations must have access to a well-integrated continuum of health care services (as identified above).

Insurance Market Reforms

- Guaranteed Issue/Limitations on Exclusions for Pre-Existing Conditions
- Requirements for Reinsurance—Portability, Renewability
- Requirements for Community Rating/Controlling Variation in Premiums

States Implementing These Reforms:
All but Michigan, Nevada, Pennsylvania

States Considering These Reforms:
Pennsylvania

Impact:
Affects health care coverage. Any insurance market reform is likely to help disabled people, because reforms aim to make coverage less discriminatory. Some reforms attempt to make insurers grant policies to more individuals who apply—they mandate that insurers accept applicants who fall within certain broadened parameters. Others limit the number of policy applicants insurers can refuse because of pre-existing conditions. Other insurance market reforms enable individuals who suffer a catastrophic injury or illness while insured to keep their policies. Some reforms may also decrease disabled individuals' care costs by spreading costs across more individuals or limiting variations in premiums for different groups of individuals.

Creation of High-Risk Pools

States Implementing These Reforms:
Alaska, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, New Mexico, North Dakota, Ohio, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, Wisconsin, Wyoming

States Considering These Reforms:
Idaho

Impact:
Affects health care coverage. Serves as a "safety net" for individuals who cannot obtain insurance through traditional avenues. May increase access for some individuals by allowing them to purchase insurance at more equitable costs.

Long Term Care Insurance Reform

- Asset Protection
- Standardization of Coverage
- Private/Public Coverage Partnerships

States Implementing These Reforms:
Connecticut, Indiana, New York

States Considering These Reforms:
California, South Dakota, Vermont

Impact:
Affects availability/coverage for long-term care benefits. Few Americans have long-term care insurance. Because it is not regulated, fraud and abuse disproportionately plague the industry. Individuals would benefit from uniform standards for the industry. Long-term care policies currently available are also cost-prohibitive for most Americans; elderly and disabled individuals, who most need the services available through these policies, cannot afford them unless they purchased policies as younger adults or in advance of their disabilities. Many disabled or elderly individuals would benefit from polices that meet their long-term care needs and shelter them from excessive out-of-pocket costs.

Special State Initiatives for Disabled Individuals

States Implementing These Reforms:
Indiana, Massachusetts

States Considering These Reforms:
None

Impact:
These special initiatives' impacts are not yet assessed, but, given disabled individuals' special needs, are too often unmet. Some of most state systems' failings

include lack of case management, lack of care coordination, and lack of access to long-term care services that enhance many disabled individuals' quality of life and independence. Special state programs could be extremely beneficial to fill such service gaps.

A special Indiana program covers the cost of elderly and disabled residents' care after they have exhausted other revenue sources. The goal of Indiana's "CHOICE" program is to encourage maximum independence for aged and disabled persons (identified by their through inability to perform activities of daily living) through the use of home-based services. Indiana's program offers access to services that are not available through most state Medicaid programs. It also offers case management services, which promote the most effective use of care and could conceivably, therefore, save state monies. The program is similar to the community and home-based care program contained in Title II of the Clinton Administration's national health care reform legislation, the American Health Security Act.

Massachusetts' plan is designed to remove work disincentives for disabled populations. It offers disabled employees opportunities to purchase coverage equal to that of the Medicaid package—if employers offer insurance, the disabled employee may purchase a supplement to bridge the difference in benefits between his new plan and the Medicaid package.

Key Elements of State Health Care Reform Plans' Successful Accommodation of People with Disabilities

PVA identified some state proposals or reforms that would enhance health care coverage, service availability, or accessibility for people with disabilities. Under most reforms, however, there remain problems to solve to better serve the disabled population. Below are PVA's recommendations to improve access and quality of service delivery for disabled citizens.

- Reform plans should incorporate medical facilities dedicated to specialized care delivery (such as rehabilitative, long-term care and other chronic care programs) in their communities' health networks. Such vertically integrated delivery systems can meet disabled individuals' specialized and mainstream care needs.
- States should monitor rehabilitative facilities and other chronic care providers' adherence to rigorous quality standards to reward licensure. Failure to maintain specified performance standards should result in probation and, if necessary, closure of the facility.
- States should augment long-term care benefits for disabled persons, to maintain or enhance their independence and quality of life. Indiana's "CHOICE" program is a good example of a state program for elderly and disabled individuals that provides a broader continuum of care for eligible state residents than most other states provide.
- States should seek Medicaid waivers to provide long-term Medicaid benefits in the most cost-effective and therapeutic settings. Lack of reimbursement for many home and community-based services has stifled development of this industry whose services disabled people need. Reimbursement should cover non-institutional care (personal assistance or home- or community-based services), when it either complements or substitutes for institutional care for eligible beneficiaries. In addition, state and federal programs must continue to adequately provide for beneficiaries' institutional care needs.
- States should provide adequate health care coverage to motivate disabled populations to enter or re-enter the labor market. Disabled individuals who are productive tax-payers help to finance their own care[1]

States reforms must consider the needs of their citizens with long-term care needs. While states struggle to meet their residents' needs, many officials are compromising "breadth" for "depth". The result of the compromise can leave disabled residents who need ongoing comprehensive services worse off than they are today. States need to carefully examine their reform proposals to ensure that their disabled populations' needs are adequately protected. Failure to do so frequently results in more intensive acute care needs for disabled people and greater care costs for the individual and, often, the state which funds their care. Most state plans also fail to address the following concerns.

- States should examine the cost-effectiveness of providing case-management services to disabled persons.
- States should disseminate information to disabled persons about providers who can and will accept them. These networks would identify both specialists to address individuals' specific conditions and generalists who can disabled peoples' primary care needs.
- States should recruit physicians and other clinicians to provide services to disabled people. They should offer training for individuals who express interest in providing services.
- Should a state define a basic benefits package to be delivered to state residents through qualified providers, that state's disabled residents should receive the same benefits. In addition, residents should not lose access to additional benefits specified in the state's Medicaid program or available through other state programs (for example, Workers' Compensation).
- Reimbursement methodologies for long-term care must change. States embarking upon long-term care insurance reform must couple it with reimbursement reform for federal and state financed long-term care programs. Programs must reimburse for services in the most appropriate settings—both institutional and non-institutional. Long-term care programs should serve individuals based on their degree of disability, not their incomes. Cost-sharing requirements should ensure that those who can afford to pay their fair share for these services do so.
- Providers who operate "centers of excellence" in states with reform efforts should include non-state residents now receiving their care from those sites. Instead, states should develop partnerships with state-run agencies or reciprocity for services rendered to out-of-state residents. State networks should provide specialized services to residents that need them, even if doing so means establishing relationships with providers outside the state boundaries.

State Health Care Reform VA Pilot Programs

Legislation under consideration in the U.S. House and Senate would give VA health care facilities in certain states unprecedented flexibility to reorganize their delivery systems and expand benefits. Exemption from many federal mandates would enable VA providers to interact and compete on an equal basis with other providers in those states facing major health care reforms. Current federal centralized management, financing, and regulation, coupled with eligibility limitations, could put many VA health care facilities at distinct disadvantage with other providers in states seeking to provide universal coverage and standard benefit packages. Even partial reforms, such as Medicaid expansions, could eventually erode VA's patient base and undermine its contribution to veterans care in those states. To survive under these reforms and become a full partner in new state health systems, VA medical facilities must be administratively and financially flexible. States need similar legislation to fully "blend" state and federal systems into a successful working partnership.

Legislation, H.R. 4013, introduced by Representative J. Roy Rowland (D–GA) in the House and S. 1974 introduced by Senator John (Jay) Rockefeller, IV (D–WV) in the Senate would authorize VA to establish pilot programs in certain states with advanced health care reform proposals. The bills would give VA facilities in those states broad administrative independence and budget flexibility. They would free VA facilities from many encumbering federal regulations regarding hiring, procurement and contracting. Most importantly, the bills would eliminate VA's current fragmented, "patchwork" eligibility system which provides full coverage for some veterans and only partial, rationed coverage for others. The legislation would enable VA facilities in those states to offer a benefit plan that could match the basic comprehensive package offered by the state under health care reform.

The pilot programs should give VA facilities a chance for survival, but only in those states currently facing major reforms. The legislation provides no mechanism for extending its provisions to VA facilities in states that might enact similar reforms. Both bills limit the number of pilot states to five, leaving selection of those states to VA. Regardless of the timing or the scope of national reforms, all fifty states inevitably could move on their own to make changes and adaptations in the structure of health services provided within their borders. VA must have the flexibility to react in many different ways to these potentially unique challenges.

PREPARED STATEMENT OF THOMAS L. GARTHWAITE, M.D., PRESIDENT, NATIONAL ASSOCIATION OF VA CHIEFS OF STAFF (NAVACOS)

The National Association of VA Chiefs of Staff represents the clinical leaders of VA medical centers. These leaders are deeply worried about the impact of state health care reform initiatives on the future of their medical centers and their ability to deliver needed services to the veterans they serve. Each state reform effort presents a unique set of issues which can only be solved by local VA leaders who are given the freedom to create and implement unique solutions. Ten chiefs of staff in nine different states were consulted in preparing this testimony and they are in substantial agreement regarding the immediate legislative and regulatory changes necessary to assure that all VA's will thrive in the new health care system.

1. A VA which must submit every contract to higher authority for review will not thrive. We know that there will be significant delays in gaining central approval of contracts. Such delays will slow implementation and frustrate all parties involved in the contract. We will need broad based and decentralized contracting authority to allow us to purchase individual services from various providers.

In addition to the freedom to write contracts quickly and locally, we must be allowed to develop long term relationships with our suppliers to continuously improve the product and the business relationship. Therefore, it will also be necessary that we be permitted to write sole source, non competitive, multi-year contracts where they will be of benefit to the VA medical center and the veteran. Since many of our agreements and contracts will be with affiliated medical schools, it is time to establish trust with all involved groups regarding the benefits derived from affiliations. Now is a key time to cement affiliations rather than continuing to drive these synergistic organizations apart.

There are potential savings for VA's and affiliates in contracts which allow consolidation of overhead. Some estimates have suggested that overhead is 20-25% of health care expenditures. Areas which might be consolidated include billing systems, purchasing, training, radiation safety, quality assessment mechanisms/expertise/software, medical waste disposal, laundry, library, medical media, and others. For the many VAMC's which are in close geographic proximity with an affiliated medical center, much flexibility to consolidate operational aspects could significantly enhance efficiency and, therefore, marketability for both institutions.

New types of contracts will be needed. Market research and planning are new to VA and will be easier to obtain by contract than in-house development. Contracts with groups of rural physicians may be desirable to provide primary care in remote sites. Flexibility will be key to effectiveness as we look for creative solutions for obtaining necessary services to be a comprehensive health care system.

2. VA medical centers must be exempted from artificial FTEE ceilings and floors. For example, we must be able to hire extra nurses after graduation when they are available. We must be able to hire our professionals based on need with the mix that makes sense for us at the time. The goal must be efficient, quality health care rather than meeting an FTEE target.

Similarly, the rigid categorization of resources without flexibility to move among various accounts results in considerable inefficiency. It may make sense to remodel to consolidate staff, yet we may have to wait years to get the project approved. In the meantime, the inefficiency may have cost more than the project. The ability to move freely between categories (personnel, operating funds, projects, automated data processing, equipment) would allow more rational use of resources than currently is possible and allow us to meet additional demands such as providing data for "quality report cards."

3. There is universal enthusiasm for eligibility simplification. While comprehensive eligibility reform would be ideal, we recognize the difficult choices inherent in clearly defining the eligibility of every veteran. However, simplification and modernization of many eligibility rules would enhance our ability to produce a marketable product.

4. We are aware that there may be a desire to limit the freedoms to deal with state reforms to a few demonstration projects. We believe it would be unwise to allow VA medical centers in some states with legislated programs to adapt to state initiatives while denying that opportunity to others. By the time a few pilot projects have been completed, many VA's will have lost the battle.

5. Many VA medical centers were built for inpatient care. Modernization has been inadequate to update all medical centers to efficiently provide the expanded outpatient care programs of today. Additional nonrecurring funds will be necessary to replace certain facilities and to modernize others to provide tomorrow's care.

6. A key to any competitive venture is an accurate understanding of the marketplace. There are currently OMB restrictions on surveys involving ten people or more. Enhanced ability to understand our customer's need via carefully designed local surveys will be key to our survival and the quality of care we deliver.

7. A massive overhaul of the personnel system should be considered. The rules do not allow us to reward the behaviors we desire, nor do they facilitate the removal of those whose contribution to the organization is minimal. While such an undertaking is beyond a quick solution, it is time to start the long journey. Immediate action to permit more liberal use of incentive pay is needed. Further reform of physician pay would allow flexibility to meet community pay structures and to reward the quality, quantity and type of work performed. NAVACOS is honored to be allowed to participate in this dialog regarding the VA role in state health care reforms. We have identified additional issues which will need attention for VA to flourish under rational health care reform. Regardless of the final reform plan, we must work together to improve VA health care.

RESPONSE FROM MR. MANLEY TO QUESTION BY SENATOR MURKOWSKI

It is our understanding that the 50 percent of the lowest cost plan premium which Washington State employers must pay is deductible by the employer as an ordinary and necessary business expense under current federal income tax law.

The State of Washington currently has no income tax. It imposes an excise tax on businesses for the act or privilege of doing business known as the Business and Occupation (B&O) tax. Since it is not an income tax, no deductions for labor, materials or other costs of doing business are generally provided. Therefore, there is no general deduction provided for employer-paid health insurance premiums. However, the state health reform law does require the Health Services Commission to submit a recommendation to the legislature providing for a state tax credit for employers of less than 500 employees against the B&O tax of up to 40 percent of the employer's share of the premium paid on behalf of dependents of its employees.

Additionally, recognizing the impact of health reform on small employers, the state law requires the Washington Health Services Commission to administer direct financial aid to employers of less than 25 employees. This is initially funded with the lesser of $150 million or 25 percent of the cost of the uniform benefits package per employer's insured employee or dependents.

WRITTEN QUESTIONS FROM CHAIRMAN ROCKEFELLER TO MR. BOLLINGER AND THE RESPONSES

Question 1. Please list your suggestions of the most essential elements for a state-based pilot program.

Answer. 1) Mandatory comprehensive benefit package and eligibility for enrollees to receive the full continuum of care.

2) Adequate and stable funding base, provided through additional appropriations not taken from existing system funding.

3) Freedom to move services into the community and closer to the patient population to improve access.

Question 2. How many states do you think should be included in a health care reform pilot program?

Answer. Initially, we recommend that four states be included: Washington, Oregon, Minnesota and Florida. We do not believe that Vermont is ready with its reforms at the present time to be included as a pilot program state. Tennessee's reforms are not comprehensive enough to have a serious impact on VA at this time.

We do recommend that language authorizing the pilot programs provide a mechanism whereby VA and the Congress can include additional VA facilities into pilot programs in additional states that may enact reforms. Full implementation of national health care reform, even if enacted this year, could be many years down the road—enough time for additional states to enact their own reforms. VA facilities in those states will need the ability to react and compete under those reforms.

Question 3. What suggestions do you have to make sure that VA Central Office would give state faciiities the flexibility that you believe they will need?

Answer. Individual managers of VA AHP's will have to assume the same standards of independence and flexibility as other providers in their geographical area in order to make VA successful in a reformed health-care environment. This flexibility can be achieved by a careful review and modification of

existing VA regulations. The pilot programs can be very useful in making this assessment. At the same time, as a national health care system tasked with a traditional federal responsibility, VA must maintain a centralized structure that will: set policy, see that policy is carried out, assure accountability and protect the system's obligations to veterans.

PVA is increasingly concerned that competitive forces along with shrinking resources could lead many VA medical centers to abandon those additional benefits, such as specialized. care for veterans with spinal cord injuries, extended rehabilitation, prosthetics, mental health services and long-term care. All of these services are part of the traditional structure and focus of the veterans health-care system. They are also benefits which are over and above the services authorized by any state or national health care reform plan. A certain degree of centralized supervision and policy direction is mandatory to ensure the continuity and availability of these services. PVA urges the Committee to ensure that these programs are clearly defined in the mission of a reformed VA health care system to see that eligible veterans can have ready access to the full range of specialized resources when needed.

Question 4. What are your best estimates of the average cost per veteran, per year for providing a basic package of services, similar to that in the Clinton plan, compared to the average annual cost per VA patient today?

Answer.

ROUGH ESTIMATE OF CURRENT COST PER PATIENT IN VA

PVA's most recent analysis of these costs utilizes medical care appropriations for FY 1987 through 1992 factored by an estimate of routine veteran users for that time period.

Total appropriations FY 1987-FY 1992 $67,920,012,000 Divided by 3,000,000 unique veteran routine users. (This figure does not include such patients as C&P exams, one-time users, VA employees) yields the cost per patient for 6 years: $22,640, or $ 3,773 per veteran per year.

ESTIMATE OF FUTURE COST PER VETERAN PATIENT UNDER THE CLINTON PLAN

Studies of VA inpatient admissions indicate that up to forty percent VA hospitalizations are inappropriate—providing care that should have been given in alternative, more cost-effective settings. The system has been trapped into these inefficiencies by its fractured, inequitable eligibility system which restricts outpatient treatment for most veterans.

Under health care reform, the standard provision of outpatient and primary care services will alleviate this problem. Undoubtedly, the increased eligibility will create additional workload, but, if competitive pressures have the desired effect on VA managers, these additional services should be conducted in a more cost-effective manner than they are today.

PVA does not envision that the costs of all new benefits provided under health-care reform will be covered by merely shifting existing resources and becoming more efficient. VA patients are older and have more serious health problems that patients in private hospitals. The Congress must ensure that VA receive adequate reimbursement in the form of appropriations, premiums and third-party payments that adequately reflect the true cost of delivering quality care to this population.

Question 5. in order to succeed under health care reform, VA health programs need to attract patients. However, we also have to make sure there are enough resources to provide quality care on a timely basis to all those who seek VA care. A pilot study can help us gather the information we would need for national health care reform. At this point, what are PVA's estimates of the likely increase or decrease in the number of patients under health care reform? And specifically, can you estimate the number of core veterans who do not currently have access to comprehensive VA outpatient care, who would qualify for such access for the first time under health care reform?

Answer. PVA's original analysis of the impact of health care reform on VA services contained in the 1993 report, Strategy 2000 contained a hypothetical "worst case scenario" under which VA could lose up to 50 percent of its medical and surgical (acute) workload. The "worst case scenario" is still widely cited (inappropriately) by many today as being a deathknell for the VA system.

The "worst care scenario," was developed prior to the inclusion of VA within any health care reform proposal. It was based on the following assumptions:

1. The reformed national health care program would provide a rich benefits package unavailable at VA facilities.

2. The national basic benefits package could be provided to veterans with VA eligibility outside VA with little or no out-of-pocket costs.

3. The VA health care system would continue to be seriously underfunded

In other words, the "worst case scenario" assumed that VA would not be included in any health care reform scenario; eligibility reform, providing the full continuum of care at VA, would remain an illusive goal; and that VA would continue to be severely underfunded, suffering from a deterioration in infrastructure and service delivery capability.

The "worst case scenario" is not a valid assumption today. VA has been included, at least so far, in the Clinton plan. Under the Administration's proposal the system will be allowed to offer a national basic benefit package addressing the full continuum of care and offering, at least, the perception of eligibility reform and a level playing field between VA and non-VA health care entities. VA might even have an advantage over the private sector in attracting veterans to join its health plan, as core group veterans, service-connected and non service-connected, would not be required to pay any premiums, co-payments or deductibles which would be required outside VA even at subsidized rates. At a minimum, VA might not lose great numbers of its present patient base who opt for VA care (even with all its eligibility inequities and bureaucratic encumbrances) purely on the basis that it doesn't cost anything. Funding problems are the only ingredient in the "worst case scenario" that will remain a perpetual reality.

With identical VA/non-VA benefits packages, attracting and maintaining a stable VA patient base will rely on a completely different set of variables. Lack of out-of-pocket costs will have its draw for many veterans seeking VA care. However, that allure will lose its luster when balanced against the ease of obtaining services, the proximity of the services for the veteran patient, the perception of the quality of those services (amenities), and the amount a veteran might have to pay for comparable services balanced against the ease

of obtaining those services. How VA responds to these factors will vary from facility to facility.

In PVA's opinion, there is no way to estimate now, when health care reform has not been passed, a benefit package agreed to, and VA AHP's established, how individual VA medical centers are going to respond and compete successfully for veteran patients. Provided the resources and management tools the system will have every opportunity to compete and thrive. But, each facility is going to face a different challenge which could have as much to do with geography as it does with the age of the hospital and what kind of staff they have in the admitting room. Some facilities are going to be successful and some are not. The only assurance we can make at this time is that pending health care reform along the lines of the Administration's bill, the "worst case scenario" should be considered a "dead horse."

The number of core group veterans who do not currently have access to comprehensive VA outpatient care and who would qualify for such access for the first time under health care reform is as follows. (Data prepared by the VA Strategic Planning Office.)

Service-connected 0-20	2,450,033
Service-connected 30-40 percent	459,041
Non service-connected low income	4,884,117
Non service-connected, pension and A&A	662,975
Total	8,456,166

The figure does not include special category veterans, World War I, prisoners of war, exposure to radiation, herbicides etc.

Question 6. It's going to be difficult for Congress to provide an adequate level of appropriations if we don't know in advance how many core veterans will choose VA. Do you have any suggestions for how the VA pilot program can help us gather this kind of information?

Answer. The experience gathered from a pilot study will be artificially constrained if a facility or group of facilities in a state are limited in providing improved services and expanded eligibility only to veterans living in that state. To obtain a true reading on the impact of reforms on VA utilization—if not for equity reasons-the pilot program must ensure that all veterans, on an enrollment basis, within the *service area* of the VA facility, even if it goes beyond state lines, be eligible to receive the same benefit package.

WRITTEN QUESTIONS FROM CHAIRMAN ROCKEFELLER TO MR. DETERS AND THE RESPONSES

Question 1. How quickly do you need legislation in order to participate in health care reform? Please briefly describe the deadline you are under in order to participate in health care reform.

Answer. Immediately. Starting January 1, 1994 Tennessee put in place Health Care reform in the form of "TennCare". There have been almost one million citizens enrolled including many veterans and the formation of 12 state wide Managed Care Organizations. The VA facilities in Tennessee need to be able

to participate as providers and need rapid legislative relief. There is an ongoing effort, on the part of the VA facilities in Tennessee, to plan for inclusion in TennCare in August-September 1994. That will be necessary to compete in the current health care arena. Without necessary enabling legislation we will be unable to not only compete but we will also continue to lose veteran patients to other health care organizations, making it increasingly difficult to catch up.

Question 2. Which areas specifically do you believe should be delegated to the State level VA, rather than to Central Office in Washington.

Answer. Local authority to contract for services, removal of restrictions on personnel resources, freedom to utilize consultants, ability to shift resources within a facility's defined budget, authority and mechanisms for billing and utilizing captured resources as well as providing health services packages to dependents and defining a benefit package similar to TennCare.

Question 3. What is your best estimate of the average cost per patient for providing a basic package of services, similar to that in your state's plan or in the Clinton plan., compared to the average cost per VA patient in your state today?

Answer. The basic benefits package of services that has been defined under the TennCare plan includes some services that we currently do not provide since we have not been involved with dependent care. The estimates of the cost for the full range of services offered under TennCare has been established by a capitated rate that slides from $1240 to around $1600 per patient per year. The average cost for VA patients per year, with our existing benefits package is estimated at around $1,080 per outpatient and $6,600 for inpatients per year. These cost do not include specialized services such as transplantation programs which are currently centrally controlled and funded. The addition of services such as family planning, preventive dental, health screenings and health education would add an estimated $84 per year per patient. In viewing this comparison there is one major disparity in that the capitated rate set by TennCare and the associated actuarial tables are set against a Risk Pool that is different than what is encountered in the VA patient population.

Question 4. A reformed VA system that provides a no-cost comprehensive basic package might attract many veterans with service connected disabilities who are currently receiving most of their medical care in non-VA facilities. This is especially true if VA outpatient care is contracted out to conveniently located providers throughout the state. What are the estimates of how many core veterans who are not currently using VA would start to use VA in your state, and what is your estimate of the increased annual cost of these new patients.

Answer. Tennessee has an estimated veteran population of 524,000 veterans. The hospitals in Tennessee are providing services for 13 to 14% of the estimated veteran population. Nationally VA has reported that 40% of inpatients and 7% of all VA health care users have a SC disability. Additionally it is estimated that 69% of veterans use some health care services but only 12.9% use some component of the VA system . Using this as a base, if 69% of the 524,000 veterans used VA services we could see 361,560 system users. Of these 7% 25,310 would have a service connected disability. The 1990 census for Tennessee identified (24.9%) were 65 or older. This must be taken into account since these individuals would be Medicare eligibles.

We are currently estimating a 2 to 3% growth rate per year for years two and three and a total market share of 20% of eligible veteran population. Based on VA estimates of 524,000 this equates to 104,800 veteran patients, a gain of 31,440 patients over three years. Of these (25%) 7,860 would be Medicare eligibles, (20%) 6,280 may receive inpatient care with (80%) 25,160 receiving outpatient services. The additional annual cost for these veterans would be $24,577,862 statewide. This cost would increase if family plans were developed and provided to dependants. This additional cost would be covered by the following:

1) Some additional appropriations for mandatory veterans not previously treated by VA.

2) Transfers of funds from other programs such as CHAMPUS, CHAMPVA or Medicaid.

3) Retained billings for higher income, insured veterans.

4) Reimbursements from state for higher risk population coverage.

WRITTEN QUESTIONS FROM CHAIRMAN ROCKEFELLER TO DR. GREEN AND THE RESPONSES

Question 1. How quickly do you need legislation in order to participate in health care reform? Please briefly describe the deadlines you are under in order to participate in health care reform.

Answer. Legislation to participate in health care reform is needed as soon as is legislatively possible but certainly within six (6) months. The situation in Vermont is as a best educated guess as follows:

a. Legislation expected by June.

b. Regulations promulgated—December–March

There is a very strong sentiment that universal access will be achieved by 1996.

We need the legislation so we can make a smooth operational transition of incorporation into the state plan as it evolves. I have enclosed an early draft of the house proposal re: VA. We wish to avoid a situation where we are seen as an interloper into the process. We will be much farther ahead being seen as a collaborator who is moving along with the rest of the providers.

Question 2. Which areas specifically do you believe should be delegated to the State level VA, rather than to Central Office in Washington?

Answer. I believe that all operational decisions about

- Contracts
- Hiring, firing and classification of personnel
- Structuring of programs (within centralized policy)
- Budget management
- Pay for personnel (under general but not detailed guidelines)
- Leasing, equipment needs and purchases

must be delegated to the local VAMC.

Question 3. What is your best estimate of the average cost per patient for providing a basic package of services, similar to that in your state's plan or in the Clinton plan, compared to the average cost per VA patient in your state today?

Answer. The estimated average annual cost for a veteran served at the White River Junction VAM&ROC for FY93 was between $3,850-$4,096 dependent upon the assumptions made. The $3,850 represents the total medical care appropriation with all non-direct care program costs subtracted including subtraction of capital expense. Adding back capital costs of $3,066,212 yields the higher number of $4,096. See attached detail in Attachment I.

Assuming the following:

All veterans who use the White River Jct. VAMC do not currently receive their total care from VA at WRJ. I estimate 5% not received from VA (2.4 million).

That Tertiary care services are, in an emergency, purchased from community providers and elective tertiary care sent to Boston VAMC's. Estimated cost $925,000.

That capital costs (maintenance, repair, upgrading of facility and capital replacement) should equal between 8-10% of expenses (4.8 million).

That staffing upgrades are required to improve services to the point where we would be competitive (1.8 million).

That there is no easy current way to cost out the Clinton plan for the population currently served.

I estimate a realistic capitated rate for the population currently served to be $4,646. This will escalate at a disproportional rate because of the aging of the specific population served.

If one assumes an operating margin of 5% is required for a healthy business then this would add $233 to this number. Thus the final capitated rate would be $4879±10%.

One must remember that the population mentioned is a selected population of heavy users of medical care with a considerable disease burden unleavened by a non using or lightly using population group. The rate presented is approximately two times the cost per average Vermont citizen (total heath care expenditures ÷ total population).

Question 4. A reformed VA system that provides a no-cost comprehensive basic package might attract *many* veterans with service-connected disabilities who are currently receiving most of their medical care in non-VA facilities. This is especially true if VA outpatient care is contracted out to conveniently located providers throughout the state. What are the estimates of how many core veterans who are not currently using VA would start to use VA in your state, and what is your estimate of the increased annual cost of these new patients?

Answer. The total number of service connected veterans in the state of Vermont is 4843 of which we currently serve 3392. This leaves 1451 service connected veterans not served. I estimate that it would be possible to attract

between 20-30% of these or between 290-435 veterans. I have no way to estimate the loss of current users of this VA of SC veterans should Universal Access be achieved. Universal Access would create 100% vulnerability. It is my belief that Vermont would find it to its advantage to maintain every federal dollar devoted to care for veterans in the state. Where those dollars went would determine the viability of the VAMC.

The numbers presented in answer to this specific questions do not include the veterans we serve from new Hampshire. Approximately 40% of our workload comes from NH. One can assume rough proportionality of distribution of SC veterans (NH has approximately 12,800 such veterans).

ATTACHMENT I—FY 93 MEDICAL CARE APPROPRIATION EXPENDITURES

Total Medical Care (FY 93)	$ 53,319,668
PTSD	(583,540)
Ethics	(204,613)
DMMS	(174,000)
OSHA	(35,663)
Outcomes	(152,039)
Mobile Van	(608,488)
VT College Study	(44,615)
Vet Centers	(419,332)
Capital Expenditures	(3,066,212)
EBTPU	(28,186)
	$48,002,980

$ 48,002,980 ÷ 12,469 Unique SSN = $3,850

ATTACHMENT II

(Draft No. 1 - H.645) 2/28/94 - 4:20pm - HWO (1.2)1410A

* * * Integration of Veterans' Health Care * * *

Sec. x. REPORT ON VETERANS' HEALTH CARE SERVICES

(a) The general assembly finds that the White River Junction Veterans' Medical and Regional Office Center is a critically important provider of care for Vermont veterans and their families, and that Vermont desires to maintain and support the Veterans' Center as a health care option for Vermont veterans and their families during this period of reform of Vermont's health care system. Accordingly, it is the purpose of this section to strengthen the links between Vermont's health care system and the Veterans' Center, with the goal of establishing an integrated, collaborative relationship that recognizes and builds on existing strengths and special services.

(b) The Vermont health care authority shall report to the House Health and Welfare Committee and the Senate Health and Welfare Committee on or before January 1, 1995 on the authority's recommendations for integrating the Veterans' Center into the Vermont health care system on a cooperative and

collaborative basis, including making the best use of the Center's special services relating to spinal cord injury, post traumatic stress disorders, and other specialized services, and providing access to primary care through satellite clinics of the Center. The authority shall engage in extensive discussions with the Veterans' Center before developing its recommendations. The authority shall also consult with the Medical Center Hospital of Vermont, the Dartmount-Hitchcock Medical Center, and other providers as may be appropriate to the purpose of this section. The authority's recommendations shall include such legislative recommendations as the authority deems necessary to integrate the Veterans' Center and the Vermont health care system in a collaborative, effective system of care.

(c) The Vermont health care authority shall initiate discussions with the University of Vermont Medical School, the White River Junction Veterans' Center, and other appropriate parties regarding specialized education and training opportunities in collaboration with the Veterans' Center for medical school students, interns and residents.

WRITTEN QUESTIONS FROM CHAIRMAN ROCKEFELLER TO MR. MANLEY AND THE RESPONSES

Question 1. How quickly do you need legislation in order to participate in health care reform? Please briefly describe the deadlines you are under in order to participate in health care reform.

Answer. In order to meet the State of Washington implementation schedule for certified health plans, we will need to have legislation enacted *and* be officially selected as a pilot state before August 1, 1994. The precise deadline for being approved by the State to participate as a certified health plan is tied to the State legislature approving the Uniform Benefit Package of benefits. This is planned to occur sometime between January 1 and March 31, 1995. To become operational as a certified health plan, we need to act as soon as possible on such things as contracting for actuarial data and marketing expertise, and to begin forming networks with private providers.

Question 2. Which areas specifically do you believe should be delegated to the State level VA, rather than to Central Office in Washington?

Answer. (1) Financial management of all revenues derived from premiums, from other insurance plans, and from other providers. (2) All contracting and leasing decisions made which have any bearing on our participation as a certified health plan. (3) All decisions regarding capital expenditures financed through revenues or through VA Investment Plan funds, should they be forthcoming. (4) The authority to allocate appropriated funds to meet patient care needs, without restriction. (5) The authority to carry out any reorganizations necessary to maintain effective and efficient operations.

Question 3. What is your best estimate of the average cost per patient for providing a basic package of services, similar to that in your state's plan *or* in the Clinton plan, compared to the average cost per VA patient in your state today?

Answer. We estimate the average cost per *patient* (as opposed to *enrollee*) for providing the state's Uniform Benefit Package will be about $2,120. If the patient's co-payments/deductibles are added, the cost is estimated to be about

$2,650 (these figures exclude education & research, beneficiary travel, and other non-treatment related costs). This compares to a current cost per VA patient of about $3,300, excluding non-treatment related costs. The difference between the estimated cost for the state Uniform Benefit Package and VA cost is likely due to the more comprehensive benefits currently provided by VA; e.g., Nursing Home Care, mental health, and Prosthetics, and the average age of the veteran population served. In 1992, the State of Washington estimated the cost to provide the Uniform Benefit Package to the general population would average $1536 per *enrollee* per year. The difference between the State projection per enrollee and the VA estimate per patient is attributed to the projection that about 60% of *enrollees* will receive care; i.e., become patients, each year. We must caution that good data is not readily available; consequently, please regard all numbers as very rough estimates.

Question 4. A reformed VA system that provides a no-cost comprehensive basic package might attract *many* veterans with service-connected disabilities who are currently receiving most of their medical care in non-VA facilities. This is especially true if VA outpatient care is contracted out to conveniently located providers throughout the state. What are the estimates of how many core veterans who are not currently using VA would start to use VA in your state, and what is your estimate of the increased annual cost of these new patients?

Answer. The term "core veteran" has not been defined. The precise definition has the potential to greatly increase the amount of care funded by the federal appropriation within the state. Using the current Congressionally mandated eligibility and funding rules, 51,281 unique Washington state patients received some level of treatment in FY93. Approximately 30,800 of these had a service connected rating; the remainder (est. 20,481) were non-service connected Category A. This service is currently funded by federal appropriations.

To attempt to respond to the question, we have estimated the impact of two of several possible definitions of core veterans:

(1) If the definition of core veteran is limited to *all* service connected veterans receiving disability compensation (i.e., a rating of 10% or higher), and all of these veterans elect the VA plan, the increased cost is estimated to be $41,432,064. The basis of this estimate is that there are 56,234 compensated service connected veterans in the state. Of the estimated 30,800 service connected veterans treated in FY 93, we estimate 29,260 (95%) were compensably disabled. Subtracting the number currently treated (29,260) from the total number of core veterans under this definition (56,234), results in 26,974 potential new enrollees. Multiplying this by the estimated $1536 per member per month cost for the Uniform Benefit Package yields the estimate.

(2) If core veterans are defined as *all* service connected receiving disability compensation and Category A veterans, the increased cost is estimated at $142,416,384, if all of these veterans elect the VA plan. The basis of this estimate is that there are about 144,000 compensated service connected and Category A veterans in the state. Subtracting the number currently treated (51,281) from the total number of core veterans under this definition (144,000), results in 92,719 potential new enrollees.

Multiplying this by the estimated $1536 per member per month cost for the Uniform Benefit Package yields the estimate.

Although some revenues are to be expected from the employers of "core" veterans, it is important to note that about 38% of the compensably disabled veterans are rated at 50% or greater disability, and a large number of those with lower ratings are over age 65. NSC Category A are by definition unlikely to be employed. Therefore, the revenues from this source are expected to be very limited.

WRITTEN QUESTIONS FROM CHAIRMAN ROCKEFELLER TO DR. PETZEL AND THE RESPONSE

Question 1. How quickly do you need legislation in order to participate in health care reform? Please briefly describe the deadline you are under in order to participate in health care reform.

Question 2. Which areas specifically do you believe should be delegated to the State level VA, rather than to Central Office in Washington?

Question 3. What is your best estimate of the average cost per patient for providing a basic package of services, similar to that in your state's plan or in the Clinton plan, compared to the average cost per VA patient in your state today?

Question 4. A reformed VA system that provides a no-cost comprehensive basic package might attract many veterans with service-connected disabilities who are currently receiving most of their medical care in non-VA facilities. This is especially true if VA outpatient care is contracted out to conveniently located providers throughout the state. What are the estimates of how many core veterans who are not currently using VA would start to use VA in your state, and what is your estimate of the increased annual cost of these new patients?

DEPARTMENT OF VETERANS AFFAIRS
Deputy Assistant Secretary for
Acquisition and Materiel Management
Washington, DC 20420, March 14, 1994

HONORABLE JOHN D. ROCKEFELLER IV
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

DEAR SENATOR ROCKEFELLER: Thank you again for the opportunity to testify about MinnesotaCare. The things that I believe need to be delegated to the State or local level are: Flexibility in spending our budget, and contracting authority. However, I think the authority for each should be given to the Secretary. He can then delegate them to us as needed.

We do not yet have a fully defined benefit (or estimate) package in this State, so an accurate comparison is impossible. The Clinton plan cost and our average cost are quite similar. The real cost issue for us is how many new "mandated" patients would come to us under Health Care Reform.

Sincerely,

ROBERT A. PETZEL, M.D., *Chief of Staff,*
Veterans Affairs Medical Center
One Veterans Drive
Minneapolis, MN 55417

WRITTEN QUESTIONS FROM CHAIRMAN ROCKEFELLER TO MR. RANDALL AND THE RESPONSES

Question 1. How quickly do you need legislation in order to participate in health care reform? Please briefly describe the deadlines you are under in order to participate in health care reform.

Answer. We need legislation by the first of May 1994. The Florida legislature is now in session and is working on cleaning up some of the language in Florida's health care reform act. The current legislative session ends April 8, 1994, the first round of requests for proposals for accountable health plans has ended, and following the current legislative session, the state should be in a position to ask for the next round of proposals for accountable health plans.

Question 2. Which areas specifically do you believe should be delegated to the State level VA, rather than to Central Office in Washington?

Answer. To the maximum extent possible, all authority should be delegated to the state-level VA. Policy decisions, of course, must be retained by VA Central Office in Washington. However, all decisions involving the use of funds that are available, either through appropriation or through money collected through the health care alliances, should be delegated. In addition, all contracting authority, all purchasing authority, all decisions as to eligibility of patients, and all personnel actions should be delegated to the state-level VA.

Question 3. What is your best estimate of the average cost per patient for providing a basic package of services, similar to that in your state's plan or in the Clinton plan, compared to the average cost per VA patient in your state today?

Answer. Our best estimate of the average cost of providing basic services for an individual in the state of Florida is $1,320 per year, which is the target mid-point for HMO plans. The results of the first round of RFP's from the Community Health Purchasing Alliances (CHPA's) has not yet been released. This is the same target that VA should use to assure a competitive position. Our current cost of treating a veteran who seeks treatment during the year is approximately $2,800 per year. This is the cost for those seeking treatment, not a "capitation" cost. Using Alachua County as an example county, it is estimated that our annual cost of providing treatment to all who use VA over a three-year period is $1,670. It must be pointed out that this cost represents much more than the coverage provided for in a "basic" program. The cost is also inflated by the fact that VA is selected by individuals who have had less than average preventive health options. When we are able to offer care to all veterans who are eligible for care and their dependents, our costs should be at or below the target cost of $1,320 per year.

Question 4. A reformed VA system that provides a no-cost comprehensive basic package might attract many veterans with service-connected disabilities who are currently receiving most of their medical care in non-VA facilities. This is especially true if VA outpatient care is contracted out to conveniently located providers throughout the state. What are the estimates of how many core veterans who are not currently using VA would start to use VA in your state, and what is your estimate of the increased annual cost of these new patients?

Answer. It can be assumed that the service-connected veterans as well as the Category A nonservice-connected veterans who currently use VA will continue to use VA under health care reform. When dependents are considered, with an average family size of 2.2, the 162,000 veterans Florida VA's now treat will become 356,000, or an increase of 194,000 individuals. At $2,800 each, the cost of treating a patient in an acute hospital, not the much lower cost of providing care to an enrollee, most of whom would need no acute treatment during any one-year period.

WRITTEN QUESTIONS FROM SENATOR JEFFORDS TO DR. GREEN AND THE RESPONSES

Question 1. I am aware that the White River Junction VA has voiced its interest in functioning as a pilot program for VA participation in a state health care reform program. What do you believe Vermont and White River Junction VA will be able to offer a pilot program?

Answer. A pilot at White River Junction VA can offer the following to a pilot program:

Insights and lessons about working with a state legislature to create state statutes which incorporate VA as a participant into the State Health Care Plan.

A blueprint of those issues and resources required for a VA Medical Center to make the transition from legislation, in whose creation it has been involved, to a successful operational program.

A very inexpensive prototype because of the small size of the White River Junction VA and state. The cost/benefit ration would be very good.

Question 2. What is your vision for the delivery of health care and veterans services under Vermont's health care reform initiatives?

Answer. My vision is that VA will become a collaborative partner in delivering health care rather than a raw competitor in the State of Vermont We would be acknowledged as being a choice for veterans to choose as a health care provider particularly for those veterans who are service connected and others who have incomes below established statutory limits. We would also be seen as a viable health care provider for any veteran and the families of veterans to choose. In brief, primary care would be provided within 30 minutes of the patient's home. In most circumstances, this would be contracted. Secondary hospital care would be provided at White River Junction VAMC for veterans and in most cases purchased for their spouses. Tertiary (high tech care) would be purchased in Burlington, VT, Lebanon, NH, Albany, NY or be sent to a Tertiary VA Center as appropriate. Heavy emphasis would be put on primary and geriatric care programs with great emphasis placed on keeping

patients in their homes and out of institutional beds. The White River facility would continue to be an acute secondary care hospital with specialized programs in Psychiatry, Long Term Care, Geriatric Evaluation, PTSD and Oncology.

Question 3. How has the White River junction VA worked with Governor Dean and Vermont legislators in developing Vermont's Health Care Reform bill?

Answer. We have met with the Governor to put our case forward. Additionally, we have testified to the Special Ad Hoc Committee of the Vermont House. We have ongoing liaison with the House Committee and will develop a similar liaison to the Vermont Senate. Prior to the beginning of the legislative session, we had and continue to have a seat on the Health Policy Advisory Committee which advised the Vermont Health Care Authority during the preparation of its report to the legislature. Enclosed is a draft of proposed legislation from the House Bill referencing VA.

Question 4. Will the reduction of the federal workforce (FTEE) impact on VA's ability to compete in the arena of health care reform?

Answer. The reduction of the federal workforce (FTEE) will have an impact on VA's ability to compete in the arena of health care reform. Health care is a labor intensive enterprise. It makes little difference whether it is directly delivered or contracted. Contracts will be, primarily, contracts for labor whether it be for direct care services or supporting services such as cleaning or dietary services. People remain the issue. There are major service delivery issues which, at this facility, will get worse with decrements in FTE. One cannot attract patients if one cannot deliver services.

There is little question that if VHA was allowed to restructure according to business needs, it would be possible, over time, to have a competitive system. Savings in FTE could be realized from consolidating or purchasing tertiary services. Unneeded facilities could be closed or missions redefined. The current FTE reductions are being imposed horizontally without reference to the above considerations. The proposed contracting does not take into account the almost impossible sea of regulations governing government contracts nor does it take into account the ability to contract in a particular environment.

Question 5. Are there any factors which would prevent VA's success in state health care reform? What are they and what can be done to reduce or eliminate these barriers?

Answer. Factors which would prevent VA's success in State Health Care Reform. There are a host of factors which would be material in preventing VA success. A partial list is as follows:

1. State law preventing VA from offering a health care plan and/or preventing VA from having a member of a health care plan.

Remedy: Federal law which prevents exclusion by State.

2. State law which would not allow payment via an alliance or other instrument to VA for services.

Remedy: Superseding Federal law.

3. State law which contained conditions for meeting state requirements which do not take into account the unique aspects of Federal institutions.

Remedy: Superseding Federal law.

4. The Body of Federal regulations/statutes dealing with:

a) contracting

b) personnel policies

Which preclude flexibility in rapid response to business conditions.

Remedy: Total revision.

5. Inability, at the current time, to generate a profit, to accumulate reserves, to borrow money, to receive and keep funds at the Medical Center for services rendered. The requirement to come to $0 balance at the end of every year.

Remedy: Legislation which would give broad authority to run according to prudent business principle.

6. A hierarchical, controlling central organization prone to micro-management. This, if perpetuated, will be the greatest barrier. There is no way a centralized bureaucracy can react expeditiously to local competitive conditions.

Remedy: Major decentralization.

7. Congressional action which mandates new programs and facilities without operational funding.

Remedy: I have no remedy for political reality.

8. Lack of education training for managers who have to cope with change of this nature.

Remedy: Provide education and training.

9. Lack of expertise in the area of managed care.

Remedy: Provide expertise to field stations.

10. Inaction by VA to restructure itself. [No remedy provided.]

11. Concerted lobbying by private sector to exclude VA. [No remedy provided.]

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